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Integrated and coordinated implementation of and follow-up to the outcomes of the major United Nations conferences and summits in the economic, social and related fields: follow-up to the Programme of Action of the International Conference on Population and Development

Framework of actions for the follow-up to the Programme of Action of the International Conference on Population and Development beyond 2014

Report of the Secretary-General

Summary

The present report has been prepared pursuant to General Assembly resolution 65/234, in which the Assembly, responding to new challenges and to the changing development environment, and reinforcing the integration of the population and development agenda in global processes related to development, called for an operational review of the implementation of the Programme of Action on the basis of the highest-quality data and analysis of the state of population and development, taking into account the need for a systematic, comprehensive and integrated approach to population and development issues.

The Programme of Action of the International Conference on Population and Development, adopted in 1994, represented a remarkable consensus among 179 Governments that individual human rights and dignity, including the equal rights of women and girls and universal access to sexual and reproductive health and rights, are a necessary precondition for sustainable development, and set forth objectives and actions to accelerate such development by 2015. Achievements over the ensuing 20 years have been remarkable, including gains in women's equality, population health and life expectancy, educational attainment and human rights protection systems, with an estimated 1 billion people moving out of extreme poverty. Fears of population growth, which were already abating in 1994, have continued to ease, and the expansion of human capability and opportunity, especially for women, which has

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led to economic development, has been accompanied by a continued decline in the population growth rate from 1.52 per cent per year from 1990 to 1995 to 1.15 from 2010 to 2015. Today, national demographic trajectories are more diverse than in 1994, as wealthy countries of Europe, Asia and the Americas face rapid population ageing while Africa and some countries in Asia prepare for the largest cohort of young people the world has ever seen, and the 49 poorest countries, particularly in sub-Saharan Africa, continue to face premature mortality and high fertility.

Our greatest shared challenge is that our very accomplishments, reflected in ever-greater human consumption and extraction of the Earth's resources, are increasingly inequitably distributed, threatening inclusive development, the environment and our common future.

The evidence of 2014 overwhelmingly supports the consensus of the International Conference that respect, protection, promotion and fulfilment of human rights are necessary preconditions for improving the dignity and well-being of women and adolescent girls and for empowering them to exercise their reproductive rights, and that sexual and reproductive health and rights and understanding the implications of population dynamics are foundational to sustainable development. Safeguarding the rights of young people and investing in their quality education, decent employment opportunities, effective livelihood skills and access to sexual and reproductive health and comprehensive sexuality education strengthen young people's individual resilience and create the conditions under which they can achieve their full potential.

The path to sustainability, outlined in the present framework, will demand better leadership and greater innovation to address critical needs: to extend human rights and protect all persons from discrimination and violence, in order that all persons have the opportunity to contribute to and benefit from development; invest in the capabilities and creativity of the world's young people to assure future growth and innovation; strengthen health systems to provide universal access to sexual and reproductive health to enable all women to thrive and all children to grow in a nurturing environment; build sustainable cities that enrich urban and rural lives alike; and transform the global economy to one that will sustain the future of the planet and ensure a common future of dignity and well-being for all people.

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I. Introduction: A new framework for population and development beyond 2014

1. Development is the expansion of human opportunity and freedom. This definition is inherent in the commitment made by all States Members of the United Nations to universal human rights and the dignity of all persons. It represents the shared aspiration of Governments and citizens to ensure that all persons are free from want and fear, and are provided the opportunity and the social arrangements to develop their unique capabilities, participate fully in society, and enjoy well-being.[1]

2. The Programme of Action of the International Conference on Population and Development[2] reflected a remarkable consensus among diverse countries that increasing social, economic and political equality, including a comprehensive definition of sexual and reproductive health and rights[3] that reinforced women's and girls' human rights, was and remains the basis for individual well-being, lower population growth, sustained economic growth and sustainable development.

3. The evidence of the operational review, mandated by the General Assembly in resolution 65/234, overwhelmingly supports the validity of that consensus. Between 1990 and 2010 the number of people living in extreme poverty in developing countries fell by half as a share of the total population (from 47 per cent in 1990 to 22 per cent in 2010), a reduction of 700 million people.[4] Women gained parity in primary education in a majority of countries,[5] maternal mortality fell by 47 per cent,[6] and the global fertility rate fell by 23 per cent.[7] The review also makes clear, however, that progress has been unequal and fragmented, and that new challenges, realities and opportunities have emerged.

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[1] A. Sen, *Development as Freedom* (New York, Knopf, 1999).

[2] *Report of the International Conference on Population and Development, Cairo, 5-13 September 1994* (United Nations publication, Sales No. E.95.XIII.18), chap. I, resolution 1, annex.

[3] Paragraph 7.2 of the Programme of Action defines reproductive health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life ..." Paragraph 7.4 states that "The implementation of the Programme of Action is to be guided by the comprehensive definition of reproductive health, which includes sexual health". Based on this and paragraph 7.3 which states that "... reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents", sexual and reproductive health and rights derive from rights under the definition of reproductive health.

[4] *The Millennium Development Goals Report 2013* (United Nations publication, Sales No. E.13.I.9.

[5] United Nations Educational, Scientific and Cultural Organization (UNESCO), *World Atlas of Gender Equality in Education* (Paris, 2012); United Nations Population Fund (UNFPA), *Marrying too Young: End Child Marriage* (New York, 2012); United Nations, Department of Economic and Social Affairs, Population Division (2011), World Fertility Policies 2011.

[6] World Health Organization (WHO) and others, *Trends in Maternal Mortality: 1990-2010 — WHO, UNICEF, UNFPA and The World Bank Estimates* (World Health Organization, Geneva, 2012).

[7] The decrease in the total fertility rate is calculated using the point estimates for the years 1990 and 2010 from World Population Prospects: The 2012 Revision (ST/ESA/SER.A/336).

Unequal progress

4. Research suggests a significant correlation between the education of girls, healthier families and stronger gross domestic product (GDP) growth.[8] The entry of women into the export manufacturing sector in Eastern and Southern Asia, among other factors, has been a key driver of economic growth and contributed to a shift in the concentration of global wealth from West to East.[9] Gains in the educational attainment of girls are also contributing to the success of Asia and Latin America in the knowledge-based economy.[10]

5. Nevertheless, belief in and commitment to gender equality is not universal,[11] and gender-based discrimination and violence continue to plague most societies.[12] Beyond the discrimination experienced by women and girls are persistent inequalities faced by those with disabilities, indigenous peoples, racial and ethnic minorities and persons of diverse sexual orientation and gender identity, among others. While a core message of the International Conference on Population and Development was the right of all persons to development, the rise of the global middle-class[13] has been shadowed by persistent inequalities both within and between countries. While important gains in health and longevity have been made, they are not equally shared or accessible to many.

6. Despite considerable advances in maternal and child health and family planning in the past two decades, 800 women died each day from causes related to pregnancy or childbirth in 2010,[14] and an estimated 8.7 million young women aged 15 to 24 in developing countries underwent unsafe abortions in 2008.[15] The advent of antiretroviral drugs has averted 6.6 million deaths from HIV and AIDS, including 5.5 million in low- and middle-income countries, but in far too many countries the number of new infections continues to rise, or declines have stalled.[16] In general,

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[8] United Nations Millennium Project, Task Force on Education and Gender Equality, *Taking action: Achieving Gender Equality and Empowering Women* (London, Earthscan, 2005).

[9] United States of America, Office of the Director of National Intelligence, *Global Trends 2025: A Transformed World* (Washington, D.C., Government Printing Office, 2008).

[10] Ibid.

[11] *The World's Women 2010: Trends and Statistics* (United Nations publication, Sales No. E.10.XVII.11). Data analysed from the World Values Survey (www.worldvaluessurvey.org).

[12] C. Garcia-Moreno and others, *WHO Multi-Country Study on Women's Health and Domestic Violence against Women: Initial Results on Prevalence, Health Outcomes and Women's Responses* (Geneva, World Health Organization, 2005); C. Garcia-Moreno and others, *Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-partner Sexual Violence* (Geneva, World Health Organization, 2013).

[13] H. Kharas, "The emerging middle class in developing countries", OECD Development Centre Working Paper No. 285 (Paris, OECD Publishing, 2010); F. H. G. Ferreira and others, *Economic Mobility and the Rise of the Latin American Middle Class* (Washington, D.C., World Bank, 2013).

[14] WHO and others, *Trends in Maternal Mortality* (see footnote 6 above); United Nations Population Fund, "Giving birth should not be a matter of life and death", UNFPA Factsheet (December 2012), available from www.unfpa.org/webdav/site/global/shared/factsheets/srh/EN-SRH%20fact%20sheet-LifeandDeath.pdf.

[15] I. H. Shah and E. Ahman, "Unsafe abortion differentials in 2008 by age and developing country region: high burden among young women", *Reproductive Health Matters*, vol. 20, No. 39 (2012), pp. 169-172.

[16] Joint United Nations Programme on HIV/AIDS (UNAIDS), *Global Report: UNAIDS Report on the Global AIDS Epidemic 2013* (Geneva, 2013).

fewer and fewer gains can be expected from technical "silver bullets" without making serious improvements to the health systems of poor countries[17] and addressing structural poverty and human rights violations.

7. Many of the estimated 1 billion people living in the 50-60 countries caught in "development traps" of bad governance, wasted natural resource wealth, lack of trading partners or conflict have seen only limited gains in health and well-being since 1994, and some are poised to become poorer as the rest of the global population anticipates better livelihoods.[18] It is in these countries, and among poorer populations within wealthier countries,[19] that the status of women, maternal death, child marriage and many other concerns of the International Conference have seen minimal progress since 1994, and life expectancies continue to be unacceptably low.[20] The threats to women's survival are especially acute in conditions of structural poverty, owing to their lack of access to health services, particularly sexual and reproductive health services, and the extreme physical burdens of food, production, water supply and unpaid labour that fall disproportionately on poor women.

New challenges, realities and opportunities

8. The dramatic decline in global fertility since the International Conference has led to a decrease in the rate of population growth; nevertheless, owing in part to demographic inertia, the world's population crossed the 7 billion mark in late 2011 and United Nations medium-variant fertility projections anticipate a population of 8.4 billion by 2030.[21]

9. Population trends today are characterized by considerable diversity between different regions and countries. Most developed countries, and several developing countries, have ageing populations, with declining proportions of young people and working-age adults. Even in poor countries, declining fertility rates will eventually lead to an ageing population, and the high proportion of older persons that is evident in Europe and developed countries in Asia today will characterize much of the world by 2050.[22]

10. At the opposite extreme, high total fertility rates of more than 3.5 children per woman are now confined to just 49 poor countries, mostly in Africa and South Asia, which make up less than 13 per cent of the world's population. These and other developing countries are still characterized by increasing proportions of young and working-age persons, a situation which, under the right circumstances (including a decline in fertility), can lead to a temporary "demographic bonus" but which, at the same time, challenges Governments to ensure adequate access to education and employment.[23]

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[17] WHO, *Everybody's Business: Strengthening Health Systems to Improve Health Outcomes — WHO's Framework for Action (Geneva, 2007).*

[18] P. Collier, *The Bottom Billion: Why the Poorest Countries Are Failing and What Can Be Done About It* (New York, Oxford University Press, 2007).

[19] Paul Collier, op. cit.; *State of World Population 2002: People, Poverty and Possibilities* (United Nations publication, Sales No. E.02.III.H.1).

[20] UNFPA, *Marrying too Young: End Child Marriage* (see footnote 5 above); WHO and others, *Trends in Maternal Mortality* (see footnote 6 above).

[21] *World Population Prospects: The 2012 Revision* (see footnote 7 above).

[22] Ibid.

[23] *World Population Prospects: The 2012 Revision — Highlights and Advance Tables* (ESA/P/WP.228).

11. Declining fertility rates are providing low- and middle-income countries with a window of opportunity for unusually rapid economic growth because the proportion of the population that is in the working age range is historically high, relative to the number of children and older working people. Young people can, if provided with education and employment opportunities, support higher economic growth and development. Sub-Saharan Africa will experience a particularly rapid increase in the size of the population aged 25-59 in the coming decade.[24]

12. Access to mobile phones and the Internet has raised the aspirations of young people today for lives they could not have imagined previously, and informed many of them about their human rights and the inequalities they experience.[25] Capitalizing on those aspirations will require significant investments in education and reproductive health, enabling young people to delay childbearing and acquire the training needed for long, productive lives in a new economy. And because they too will eventually be part of an ageing society, they will need opportunities for lifelong learning and for social, economic and political participation throughout their lives. They will also need the skills to be responsible stewards of the planet and the environmental legacy left to them.

13. We are living in a time of relative global peace. Although the world has experienced a precipitous decline in inter-State warfare since the end of the cold war,[26] in the two decades since 1994 deeply held distinctions based on religious and political values have become increasingly apparent, with the human rights and autonomy of women and girls a frequent touchstone of ideological difference.[27] In no country are women fully equal to men in political or economic power. However, while most States are progressing — albeit slowly — towards gender equality,[28] in a number of States the rights and autonomy of women are being curtailed.[29]

14. Internal migration, a common response to structural inequality and an integral part of the development process, was far smaller in scale in 1994, but by 2008 more than half the world's population had become urban dwellers,[30] and cities and towns are now growing by an estimated 1.3 million people per week,[31] a result of both natural increase and migration. Greater mobility, both within and between countries, means that people are living in an increasingly interconnected and interdependent world. The rapid growth of the urban population is one of the major demographic transformations of the century, and international, national and subnational leadership will be sorely needed if cities are to be places of innovation, economic growth and well-being for all inhabitants. And while the growing internal migration of young

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[24] *World Population Prospects: The 2012 Revision* (see footnote 7 above).

[25] N. Halewood and C. Kenny, "Young people and ICTs in developing countries" (Washington, D.C., World Bank, 2008). Available from www.cto.int/wp-content/themes/solid/_layout/dc/k-r/youngsub.pdf.

[26] L. Themnér and P. Wallensteen, "Armed conflicts, 1946-2012", *Journal of Peace Research*, vol. 50, No. 4 (2013), pp. 509-521.

[27] "Religion, politics and gender equality", UNRISD Research and Policy Brief No. 11 (Geneva, United Nations Research Institute for Social Development, 2011). Available from www.unrisd.org.

[28] *The World's Women 2010: Trends and Statistics* (see footnote 11 above).

[29] Human Rights Watch, *World Report 2013: Events of 2012* (New York, Seven Stories Press, 2013).

[30] *World Urbanization Prospects: The 2011 Revision* (ST/ESA/SER.A/322).

[31] Estimated average weekly growth of the total urban population between 2005 and 2010, derived from *World Urbanization Prospects: The 2011 Revision*.

people to urban areas[32] represents gains in agency, freedom and opportunity, migrants experience a host of vulnerabilities, often living in appalling conditions, without secure housing, social support or access to justice. Migration also carries particular opportunities and risks for young women, providing them with access to higher education and the labour market while residential insecurity can lead to higher risks of sexual violence and reproductive ill-health.[33]

15. International migration has become a key feature of globalization in the twenty-first century. Attracted by better living and working conditions and driven by economic, social and demographic disparities, conflict and violence, some 230 million people — 3 per cent of the world's population — currently live outside their country of origin. Migrants whose rights are protected are able to live with dignity and security and, in turn, are better able to contribute to their host societies and countries of origin, both economically and socially, than those who are exploited and marginalized.

16. With global economic growth has come a massive increase in greenhouse-gas emissions. In 2013 the concentration of CO_2 in the atmosphere surpassed long-feared milestone of 400 parts per million for the first time in 3 million years,[34] suggesting that the chances of keeping global warming of the planet to below 2 degrees Celsius above preindustrial levels is fading quickly.[35] The need for global leadership on environmental sustainability grows more pressing each day.

Fragmented implementation of the Programme of Action

17. A hallmark of the International Conference was its inclusiveness, which enabled an unprecedented level of participation from civil society, both during the preparatory process, the non-governmental organization (NGO) forums and the Conference itself, and expanded the range of issues addressed in the outcome document. The Programme of Action included 16 chapters that defined objectives and actions for more than 44 dimensions of population and development, including the interests of distinct population groups, calls for investments in young women's capabilities and concern for the implications of demographic phenomena, and recommended actions to be taken.

18. The range of subjects addressed in the Programme of Action offered the potential for a comprehensive, integrated agenda. However, in practice Governments and development agencies were selective and took a sectoral approach to implementation. Programmes promoting reproductive rights, for example, ignored quality of care and inequalities in access to services. Similarly, investments

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[32] M. Bell and S. Muhidin, *Cross-National Comparison of Internal Migration*, Human Development Reports, Research Paper 2009/30 (United Nations Development Programme, July 2009).

[33] M. Temin and others, *Girls on the Move: Adolescent Girls and Migration in the Developing World — A Girls Count Report on Adolescent Girls* (New York, Population Council, 2013); A. M. Gaetano and T. Jacka, eds., *On the Move: Women and Rural-to-Urban Migration in Contemporary China* (New York, Columbia University Press, 2004).

[34] United States, Department of Commerce, National Oceanic and Atmospheric Administration, Earth System Research Laboratory, Global Monitoring Division, Up-to-date weekly average CO_2 at Mauna Loa. Retrieved from www.esrl.noaa.gov/gmd/ccgg/trends/weekly.html on 8 December 2013.

[35] Potsdam Institute for Climate Impact Research and Climate Analytics for the World Bank, *Turn Down the Heat: Why a 4° C Warmer World Must Be Avoided* (Washington, D.C., World Bank, November 2012).

in cities failed to effectively take into account and embrace urban population growth, and in doing so left large numbers of the urban poor and other marginalized groups without land, housing security or access to critical services. In addition, decades of attention to international migration notwithstanding, large numbers of migrants both documented and in an irregular situation, continue to be excluded from full participation in their societies of destination. In numerous examples across multiple sectors, development efforts continue to fail to ensure universal respect for human rights or consistent investment in the capabilities and dignity of disadvantaged individuals throughout the life course.

Foundation for population and development beyond 2014

19. In its resolution 65/234 on the review of the implementation of the Programme of Action of the International Conference on Population and Development and its follow-up beyond 2014, the General Assembly underscored the need for a systematic, integrated and comprehensive approach to population and development, one that would respond to new challenges relevant to population and development and to the changing development environment, as well as reinforce the integration of the population and development agenda in global processes related to development. The findings and conclusions of the operational review suggest a new framework for population and development beyond 2014 built on five thematic pillars: dignity and human rights; health; place and mobility; governance and accountability; and sustainability.

20. The new framework acknowledges that the motivations for development are generated by human aspirations for dignity and human rights, for good health, and for both security of place and mobility. While these aspirations are interlinked and reaffirm one another, they offer distinct organizing thematic pillars for reviewing the numerous principles, objectives and actions contained within all the chapters of the Programme of Action. While the objectives of the International Conference touched on many different dimensions of well-being across the life cycle and many domains of population and development, they each contribute, in the main, to the fulfilment of dignity and human rights, good health, a safe and secure place to live, and mobility. Because the respect, protection, promotion and fulfilment of human rights are necessary preconditions for realizing all of the unfulfilled objectives of the Programme of Action, the elaboration and fulfilment of rights are a critical metric for determining whether, for whom, and to what extent these aspirations have been achieved.

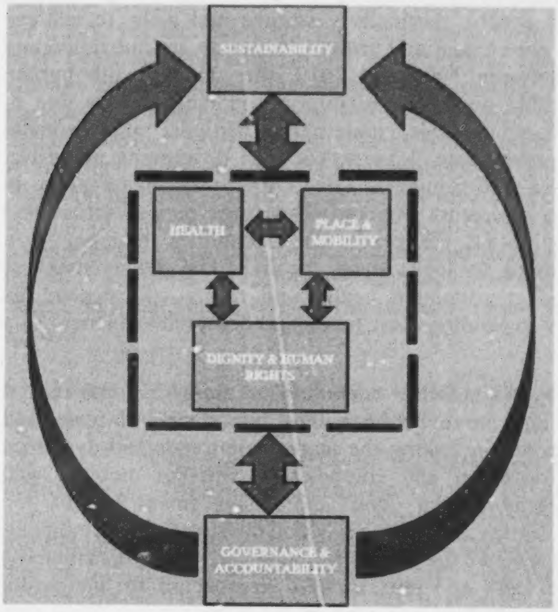
21. Furthermore, the framework acknowledges that Governments are accountable, as duty bearers and vital actors, for the realization of all development goals and the fulfilment of the aspirations of the Programme of Action.

22. Finally, consistent with objectives stated in the Programme of Action, as well as the call of the General Assembly in resolution 65/234 to respond to new challenges relevant to population and development, the framework highlights the special concerns raised by the environmental crises of today and the threat that current patterns of production, consumption and emissions pose for equitable development and sustainability. Figure I illustrates and reaffirms the core message of the Programme of Action: that the path to sustainable development is through the equitable achievement of dignity and human rights, good health, security of place and mobility, and achievements secured through good governance and accountability, and that the responsibilities of governance extend to the national and

global promotion of integrated social, economic and environmental sustainability in order to extend opportunity and well-being to future generations.

Figure 1

Thematic pillars of population and development



23. *Dignity and human rights*. The primary attention to dignity and human rights is motivated by the assertion that completing the unfinished agenda of the International Conference will require a focused and shared commitment to human rights, non-discrimination and expanding opportunities for all. Any development agenda that aims at individual and collective well-being and sustainability has to guarantee dignity and human rights to all persons. Principle 1 of the Programme of Action affirmed that all human beings are born free and equal in dignity and rights and are entitled to the human rights and freedoms set forth within the Universal Declaration of Human Rights without distinction of any kind. This is similarly affirmed and elaborated in international treaties, regional human rights instruments and national constitutions and laws. As those rights are guaranteed without distinction of any kind, a commitment to non-discrimination and equality in dignity lies at the core of all human rights treaties. This principle was reinforced in the outcomes of regional reviews as well as at global thematic meetings on the Programme of Action beyond 2014. The operational review also afforded an opportunity to focus on the recurrent question of whether achievements since 1994 have expanded opportunities and rights across all segments of society and across diverse locations. Recognizing that poverty is both the cause and the result of social exclusion and that quality education is a path to individual agency, both income inequality and education gains since the International Conference are addressed in the section on dignity and human rights.

24. *Health*. The right to the highest attainable standard of health, the significance of good health to the enjoyment of dignity and human rights and the importance of

healthy populations to sustainable development are undeniable. The International Conference recognized the centrality of sexual and reproductive health and rights to health and development. Sexual and reproductive health and rights spans the lives of both women and men, offering individuals and couples the right to have control over and decide freely and responsibly on matters related to their sexual and reproductive health, and to do so free from violence and coercion. Sexual and reproductive health and rights are essential for all people, particularly women and girls, to achieve dignity and to contribute to the enrichment and growth of society, to innovation and to sustainable development. Between 1990 and 2010, the global health burden shifted towards non-communicable diseases and injuries, including those due to ageing. At the same time, communicable, maternal, nutritional and neonatal disorders, many of which are preventable, have persisted in developing countries, especially in sub-Saharan Africa and Southern Asia. Despite aggregate gains in sexual and reproductive health indicators, marked disparities persist across and within countries, further highlighting the persistent inequalities inherent in a development model that continues to leave many behind. The achievement of universal access to sexual and reproductive health and rights will depend on strengthening health systems by expanding their reach and comprehensiveness in a holistic manner.

25. *Place and mobility.* Place and mobility encompasses the social and spatial environments that we live in and move between. The importance of place and mobility as a thematic pillar resides in linking the large-scale trends and dynamics of population — household formation and composition, internal mobility and urbanization, international migration and land and displacement — to the achievement of both individual dignity and well-being and sustainable development. Section IV of the present report reviews the changing social and spatial distributions of the human population since 1994 and puts forward approaches to integrating these changes into public policies so they can support the human needs for a safe and secure place to live and for mobility. It also highlights the need to ensure dignity and human rights for those whose security of tenure and freedom of movement are threatened.

26. *Governance and accountability.* Governance and accountability is the primary means of achieving these goals. The world has seen important shifts in the diffusion of authority and leadership since 1994, with a growing multiplicity of national, municipal, civil society, private sector and other non-State actors. The International Conference generated momentum at the national level for the creation and renewal of institutions to address population dynamics, sustainable development, sexual and reproductive health, the needs of adolescents and youth, and gender equality. The past 20 years have also seen a measureable increase in the formal participation of intended beneficiaries in the planning and evaluation of population- and development-related investments and in the elaboration of common indicators to measure development. As the world reappraises goals for the future, progress in participation is at the core, along with the generation and use of knowledge, adequate resources and cooperation, and the critical and continuing need for global leadership to implement population and development beyond 2014. International human rights protection systems have gained in authority, jurisdiction and monitoring power, and the formal participation of civil society as a political force has grown measurably since 1994, yielding important shifts in rights-based investments. Yet the political power of private wealth has never been more promising, nor more threatening, to global development, demanding more representative, public-sector, accountable global leadership.

27. *Sustainability*. Finally, sustainability reaffirms the intrinsic linkages between the goals elaborated in the preceding paragraphs on dignity and human rights, health, place and mobility, and governance, and underscores that discrimination and inequality must be prioritized in both the beyond 2014 and post-2015 agendas for the well-being of the human population and our common home, the planet. The current development model has improved living standards and expanded opportunity for many, yet the economic and social gains have been distributed unequally and have come at great cost to the environment. Environmental impacts, including climate change, affect the lives of all people, but particularly the poor and marginalized who have limited resources to adapt while having contributed the least to human-driven environmental change. This section addresses the linkages between increasingly diverse population dynamics, the environment and inequality, and builds on the four thematic pillars to put forward a set of paths to sustainability that can help to deliver dignity and human rights for all beyond 2014. The integrated and comprehensive approach to population and development set forth in the present report is essential for achieving sustainable development, as set out by Member States and the Secretary-General in their vision for the post-2015 development agenda.

Programme of Action beyond 2014: building global sustainability on a foundation of individual dignity and human rights

28. As the debates and policies on population before the International Conference demonstrated, large-scale global fears have too often been prioritized over the human rights and freedoms of individuals and communities, and at worst have been used to justify constraints on human rights. Debates on environmental sustainability, and on stimulating economic growth following the crisis of 2008, risk the same consequences. The imperative of the post-2015 development agenda is to bring social, economic and environmental sustainability together within one set of global aspirations; the findings and conclusions of the operational review argue for integrating these often disparate aims.

29. The vital importance of the paradigm shift of the International Conference — subsequently affirmed by progress in the two decades since — was precisely in demonstrating that individual and collective development aspirations benefit from a central focus on individual dignity and human rights. By updating such principles and advancing their implementation, Governments can achieve the goals set forth in 1994 while accelerating progress towards a resilient society and a sustainable future for all. Central to this exercise are laws and policies that will ensure respect and protection of the sexual and reproductive health and rights of all individuals, a condition for individual well-being and for sustainability.

30. As elaborated in the findings of the operational review described below, the ideals of equitably expanding human rights and capabilities, especially for young people, are shared by most Member States, and most Governments report having addressed efforts at reducing poverty, raising the status of women, expanding education, eradicating discrimination, improving sexual and reproductive health and well-being, and embracing sustainability. Progress is nonetheless uneven, and the persistence of inequalities is evident throughout. Much work will be needed in the decades ahead.

31. The Millennium Development Goals have been the unifying global framework for development for almost 15 years. As the United Nations considers the post-2015 development agenda, the goals and principles of the Programme of Action and the

findings of the operational review contribute important elements to fulfil human rights, equality and sustainable development.

A. The realization of human rights

32. In analysing the situation regarding individual well-being as envisaged in the Programme of Action, underlying questions have been the extent to which progress has been equitable across diverse segments of society and the extent to which human rights affirmed in the Programme of Action have been realized. Consistent with the fundamental commitment of the Programme of Action to create a more equitable world, one in which security, education, wealth and well-being would be shared by all persons, the operational review explicitly examined social and spatial inequalities wherever possible.

33. The shared vision of development, human rights and a world order based on peace and security has been at the foundation of the United Nations since its conception. Article 1, paragraph 3, of the Charter of the United Nations (1945) states that a main purpose of the Organization is to "achieve international cooperation in … promoting and encouraging respect for human rights and for fundamental freedoms for all without distinction as to race, sex, language, or religion". The Universal Declaration of Human Rights (1948) and the two binding International Covenants on Human Rights (1966) set out an expansive list of civil and political, as well as economic, social and cultural rights that Member States are obliged to respect, protect and fulfil. The human rights protection system has evolved substantially since 1948, incorporating numerous international conventions as well as resolutions, declarations, decisions and principles. A growing regional human rights protection system has emerged to complement international efforts, providing rights protections that are responsive to the context of each region.

34. While all human rights are indivisible and interconnected, a variety of treaties and policy guidance elaborate specific areas of rights. The Convention on the Elimination of All Forms of Discrimination against Women (1979) and the Convention on the Rights of the Child (1989) clarify specific rights and obligations, articulate the rights of women and children more completely, and provide guidance on how these rights are to be respected, protected and fulfilled.

35. Following as it did the World Conference on Human Rights (1993), which affirmed that all human rights are universal, indivisible and interdependent and interrelated, and devoted a special section of the Vienna Declaration and Programme of Action to the equal status of women, the International Conference on Population and Development brought together development and human rights in a compelling and operational manner. The Beijing Declaration put it simply: "Women's rights are human rights" (para. 14).

36. The International Conference on Population and Development affirmed that the widely acknowledged international commitments to human rights should be applied to all aspects of population and development policies and programmes. Building on the World Conference on Human Rights, a major achievement of the International Conference was the explicit recognition of the connection between human rights, population and development. The Programme of Action affirmed that "the right to development is a universal and inalienable right, and an integral part of fundamental human rights, and the human person is the central subject of development". Looking forward to the challenges and obligations of sustainability, the Programme of Action acknowledged that "the right to development must be

fulfilled so as to equitably meet the population, development and environmental needs of present and future generations" (principle 3).

37. The Programme of Action also affirmed that all human beings are born free and equal in dignity and rights and entitled to all the rights and freedoms set forth in the Universal Declaration of Human Rights, without distinction of any kind, such as race, sex, language, religion, political or other opinion, national or social origin, property, birth or other status (principle 1).

38. In affirming the centrality of human rights with regard to population, the Programme of Action acknowledged "that reproductive rights embrace certain human rights that are already recognized", and that these rights rest on the recognition of "the basic right of all couples and individuals to decide freely and responsibly the number, timing and spacing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health", as well as the "right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents" (para. 7.3).

39. The Programme of Action also reaffirmed civil rights of direct relevance to migration, mobility and human security. It called on all countries to "guarantee to all migrants all basic human rights as included in the Universal Declaration of Human Rights" (principle 12), and "the right to seek and enjoy in other countries asylum from persecution" (principle 13). It also provided protections for mobility, elaborating that "population distribution policies should ensure that the objectives and goals of those policies are consistent with ... basic human rights" (para. 9.3). Regarding human security, the Programme of Action reaffirmed for all persons "the right to an adequate standard of living for themselves and their families, including adequate food, clothing, housing, water and sanitation" (principle 2).

40. The 19 years following the International Conference on Population and Development witnessed the expansion of both international and regional systems for the protection of human rights, with specific advances related to many of the population and development objectives proposed in the Programme of Action. In particular, the Fourth World Conference on Women, held in Beijing in 1994, marked an important milestone for women's empowerment, gender equality and human rights globally. The Platform for Action adopted by the Beijing Conference outlined objectives and key actions regarding gender equality, including in the fields of poverty eradication, education and training, health, violence against women, women's economic participation and women's human rights.

41. The elimination of violence against women has also received substantial attention in regional commitments since 1994, with the African, inter-American, and European human rights systems all developing instruments that address violence against women.

42. Human rights laws related to mobility, in particular the rights of migrant populations, have also gained attention since the International Conference. The Programme of Action invited States to ratify the International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families of 1990 (para. 10.6); the Convention entered into force in 2003, less than a decade later.

43. Particular advances were also noted in extending the human right to dignity and non-discrimination to all persons and affording rights protections to population groups that endure persistent stigma, discrimination and/or marginalization. For

example, the Programme of Action affirmed the rights of persons with disabilities, and in 2006 the Convention on the Rights of Persons with Disabilities was adopted, formally acknowledging those rights. In 2007 the United Nations Declaration on the Rights of Indigenous Peoples was adopted by the General Assembly, recognizing the right to self-determination of indigenous peoples as well as the principle of free, prior and informed consent on all matters affecting their rights. In 1997, the International Guidelines on HIV/AIDS and Human Rights presented a framework for promoting the rights of persons living with HIV and AIDS.

44. Despite such developments, the human rights principles related to equality and non-discrimination have unfortunately remained unrealized for many groups, principal among them girls and women, and persons of diverse sexual orientation or gender identity. In some countries, laws banning certain consensual adult sexual behaviour and relationships, including relations outside of marriage, remain in force.

45. The African regional human rights system has developed markedly since 1994, notably through the adoption of the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (2003) and the African Youth Charter (2006). The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa made important advances in protecting and promoting women's rights and gender equality, elaborating international commitments within the specific cultural and political contexts of the region. In addition to affirming the rights to development, education, employment and socioeconomic welfare, the Protocol highlights the specific impact of many issues for women in Africa, including land rights and inheritance, harmful practices, HIV/AIDS and reproductive health, as well as marriage, divorce and widowhood. Globally, the African Youth Charter and the Ibero-American Convention on the Rights of Youth (2005) represents the only youth-centred, binding regional instruments to date that explicitly aim to respect and fulfil the rights of youth. These expansive documents promote youth empowerment, development and participation, and protect and promote youth rights to non-discrimination, freedom of expression, health, work and professional training.

46. Despite the numerous advances in human rights in the past two decades, as described throughout the present report, significant gaps remain in the equitable application of these rights to all persons, as well as in the development of systems of accountability.[36] The prospects and need for accountability systems are foreshadowed throughout the report and reviewed in greater depth under the heading "Governance", with specific recommendations.

B. Methodology, data sources and structure of the report

47. The methodology and activities of the operational review were developed jointly, on the basis of consultation and agreement with Member States, the United Nations system and other relevant partners identified in General Assembly resolution 65/234, including civil society and other institutions. The operational review was based on the highest-quality data generated by Member States, including the global survey of the Programme of Action beyond 2014 (2012) and country implementation profiles designed in consultation with all partners, principally

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[36] International Conference on Population and Development Beyond 2014 International Conference on Human Rights, Netherlands, 7-10 July 2012, Chair's closing statement.

Governments. In addition, global thematic conferences or meetings were held on a number of issues where more in-depth examination and multi-stakeholder discussion was required, beyond the global survey, on youth, women's health, human rights and monitoring framework for the Programme of Action beyond 2014.

48. The results of these activities, regional reviews by the regional commissions and ministerial regional reviews of the Programme of Action beyond 2014 and the source material listed below provided the basis for the analyses and recommendations contained in the present report:

- Country implementation profiles
- Global survey on the implementation of the Programme of Action of the International Conference on Population and Development
- Outcome document of the Global Youth Forum and technical papers prepared in the context of the meeting
- Report of the International Conference on Population and Development beyond 2014 International Conference on Human Rights and technical papers prepared in the context of the meeting
- Recommendations of the expert consultation on women's health: rights, empowerment and social determinants and technical papers prepared in the context of the meeting
- Recommendations of the international meeting on monitoring and implementation of the Programme of Action of the International Conference on Population and Development beyond 2014
- Reports prepared by the regional commissions based on the regional analyses of the global survey data and the outcomes of the regional conferences
- Data and analysis from peer-reviewed sources and related inter-agency processes such as special ad hoc consultations organized by the thematic groups and the secretariat of the International Conference on Population and Development beyond 2014 on the implementation of the Programme of Action
- Data, analyses and reports on financial resource flows relating to the implementation of the Programme of Action, including available cost estimates for implementation up to 2015
- Documentation issued in connection with the tenth and the fifteenth anniversaries of the International Conference on Population and Development
- Documents concerning the post-2015 development agenda that are relevant to the operational review, in particular the outcome of the Global Consultation on Population Dynamics in the Post-2015 Development Agenda and the declaration adopted at the Global Leadership Meeting on Population Dynamics and the Post-2015 Development Agenda, held in Dhaka in March 2013; the United Nations Task Team paper on population dynamics; as well as papers and outcome documents from the global thematic consultations on health, education, inequalities and governance.

49. The global survey was completed by 176 Member States and 7 territories and areas, representing all regions; it provides new data on the establishment of government institutions to address key concerns related to the Programme of Action, on the extent to which Governments have addressed selected issues in the preceding five years, and on government priorities in related domains for the coming 5-10 years.

50. Data on health outcomes, population change, gender values, socioeconomic status and education are based on evidence reported by countries and obtained through censuses; household surveys (such as demographic and health surveys and multiple indicator cluster surveys); trends and projections generated by the United Nations Population Division; monitoring systems of United Nations entities such as the World Health Organization (WHO), the Joint United Nations Programme on HIV/AIDS (UNAIDS) and the United Nations Children's Fund (UNICEF); and other surveys, including the World Values Survey, that were the results of academic collaboration requiring approval by Member States; the data were enriched by analyses drawn from technical reports commissioned as part of the operational review. Details on the methods of analysis are provided in the annex.

51. For analytical purposes, data presented in the present report have been aggregated, or grouped, into geographic regions and subregions, income groups, and more developed and less developed regions. The geographical regions or subregions used are based on the standard country or area codes and geographical regions for statistical use (M49)[37] classification of the United Nations but they may vary slightly within the report, depending on the distinct groupings used by the international organizations from which data have been drawn and/or the statistical clustering of countries according to selected characteristics. Classification of countries by income group is as provided by the World Bank, based on gross national income (GNI) per capita.[38] The "more developed countries" include all European countries, Australia, Canada, Japan, New Zealand and the United States of America. Countries or areas in Africa, Latin America and the Caribbean, Asia (excluding Japan) and Oceania (excluding Australia and New Zealand) are grouped under "less developed regions".

52. Key principles, objectives and actions contained in the Programme of Action that are representative of the relevant thematic pillar are listed at the beginning of each section.

53. The human rights mapping contained the present report was conducted by means of a review of the Universal Declaration of Human Rights; the International Covenant on Civil and Political Rights; the International Covenant on Economic, Social and Cultural Rights and the seven additional core international human rights treaties; key international and regional human rights instruments; general comments and recommendations of the human rights treaty bodies; reports of special rapporteurs; selected General Assembly resolutions; and outcome documents of intergovernmental processes that reaffirm human rights commitments.

54. Elaborations on international and regional human rights instruments that have been adopted since 1994 and that are relevant to key topics are shown in boxes throughout the report. These correspond to three levels of obligation:[39]

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[37] For the composition of macrogeographical (continental) regions and geographical subregions, see http://unstats.un.org/unsd/methods/m49/m49regin.htm.

[38] As at 1 July 2012. For further details see http://data.worldbank.org/about/country-classifications.

[39] The list of human rights documents reviewed in this report is not exhaustive. The report focuses on international human rights instruments relevant to the operational review, and does include International Labour Organization Conventions or instruments of international humanitarian law. The list of "Other intergovernmental outcomes" is selective and abbreviated, representing only several documents that were critical to this review.

(a) **Treaties, covenants and conventions** that are legally binding for States that have ratified them and that have entered into force once they have received a sufficient number of ratifications;

(b) **Negotiated outcomes and consensus statements of intergovernmental bodies on human rights**, such as resolutions and declarations that elaborate human rights commitments related to specific topics. Several **other intergovernmental negotiated outcomes** were selected in view of their importance to the operational review including conference outcomes and consensus documents which, although not human rights instruments, contain human rights standards;

(c) **Other soft law instruments**, such as general comments and recommendations of the human rights treaty monitoring bodies that offer interpretations on the content of human rights provisions included in the core international treaties.

55. The principal human rights instruments mentioned in the boxes define the foundational rights upon which the principles, objectives and actions contained in the Programme of Action are based and the mechanisms through which they have evolved over the past 20 years.

56. The text in bold type in the report indicates recommendations for addressing specific issues raised within each thematic pillar. At the end of each section, key areas for future action synthesize the main findings and recommendations of the thematic pillar. The final section concludes with seven "paths to sustainability" that define the contributions of the new framework for the Programme of Action beyond 2014 to the achievement of sustainable development.

II. Dignity and human rights

> "All human beings are born free and equal in dignity and rights. Everyone is entitled to all the rights and freedoms set forth in the Universal Declaration of Human Rights, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status. Everyone has the right to life, liberty and security of person."
>
> (Programme of Action, principle 1)

> "Advancing gender equality and equity and the empowerment of women, and the elimination of all kinds of violence against women, and ensuring women's ability to control their own fertility, are cornerstones of population and development-related programmes. The human rights of women and the girl child are an inalienable, integral and indivisible part of universal human rights. The full and equal participation of women in civil, cultural, economic, political and social life, at the national, regional and international levels, and the eradication of all forms of discrimination on grounds of sex, are priority objectives of the international community."
>
> (Programme of Action, principle 4)

57. Principle 1 of the Programme of Action of the International Conference on Population and Development affirms that "all human beings are born free and equal in dignity and rights" and are entitled to all the rights and freedoms as set forth in the Universal Declaration of Human Rights, without distinction of any kind. These

principles underscore the urgent need to eradicate all forms of discrimination and affirm that the principal aim of population-related goals and policies is to improve the quality of life of all people. The principles of the Programme of Action establish the link between dignity and human rights and individual well-being.

58. Dignity is intrinsically interlinked with human rights and fundamental freedoms. As reflected in the Programme of Action, dignity includes far more than the meeting of basic needs; it includes the right to education; to full participation in social, economic and political life; to freedom of information; to be free from discrimination and violence; to security of residence as well as freedom of human mobility; it requires that individuals be provided access to opportunities to build and renew their capabilities across the life course. Dignity includes the foundational human right to sexual and reproductive health and the freedoms to choose whom to love, whether and when to have children, and the guarantee that sex and reproduction are a source of human happiness and can be engaged in without fear of illness or a risk to health. These entitlements and freedoms are a precondition for a thriving, inclusive society, composed of resilient individuals who can innovate and adapt, and ensure a shared and vibrant future for all persons.

59. This section of the report examines progress since 1994 in the achievement of equality and non-discrimination, especially among population groups at high risk of discrimination. It identifies gaps and challenges in implementing the Programme of Action as it relates to dignity and human rights, provides concrete recommendations and highlights key areas for future action.

A. The many dimensions of poverty

60. Poverty is the deprivation of one's ability to live as a free and dignified human being with the full potential to achieve one's desired goals in life.[40] Poverty has many manifestations. It is the lack of income and productive resources sufficient to ensure sustainable livelihoods, but also includes many other deprivations, such as food insecurity; lack of health care, education and other basic services; inadequate or no housing; lack of safety or means of redress; and lack of voice or access to information or political participation.[41] The experience of poverty is dynamic, with some trapped in it while others move in and out, and many are living at the threshold.

61. Between 1990 and 2010, the number of people globally living in extreme poverty fell by half as a share of the total population in developing countries (from 47 per cent to 22 per cent), a reduction of 700,000,000 people.[42] However, despite this significant reduction in the number of people living in poverty, an estimated 1.2 billion poor people have been left behind in extreme poverty. Using a multidimensional definition of poverty that includes, for example, a measure of

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[40] *Report on the World Social Situation 2010: Rethinking Poverty* (United Nations publication, Sales No. E.09.IV.10).

[41] Programme of Action of the World Summit for Social Development, para. 19; see *Report of the World Summit for Social Development, Copenhagen, 6-12 March 1995* (United Nations publication, Sales No. E.96.IV.8), chap. I, resolution 1, annex II; *Report on the World Social Situation 2010: Rethinking Poverty*; United Nations, Economic Commission for Latin America and the Caribbean, *Millennium Development Goals: 2006 Report — A Look at Gender Equality and Empowerment of Women in Latin America and the Caribbean* (Santiago, 2007).

[42] *The Millennium Development Goals Report 2013* (see footnote 4 above).

human deprivation in terms of health, education and standard of living, the United Nations Development Programme (UNDP) estimates that, in 104 countries studied, some 1,570,000,000 people, or more than 30 per cent of the world's population, live in poverty. In fact, the number of people living in multidimensional poverty surpasses that of those living in income poverty in many fast-growing countries of the South.[43]

62. Poverty occurs in all countries, and women bear a disproportionate burden of its consequences, as do the children they care for. Because poverty has historically been measured at the level of the household, without measures of intra-household inequality, the differential poverty of women and men has been obscured. But when comparing households occupied by a single adult (with or without children), the greater poverty among women compared to men is irrefutable.[44] For similar reasons, poverty among specific population groups, e.g. persons with disabilities and older persons is equally difficult to measure. The eradication of extreme poverty is universally achievable, and is at the centre of realizing dignity and human rights for all.

63. Central to the other thematic pillars, health is vital to all conceptions of poverty. Health is necessary for the achievement of well-being and for longevity. Poverty undermines health by exposing people to poor living conditions, where sanitation, shelter and clean water are lacking, and by creating barriers to access to health, social and legal services in societies where access to services is limited to those who have sufficient resources.[45]

64. Each of these factors is in turn shaped by place and mobility. Insecurity of place, whether in the form of homelessness, limited rights to land ownership or tenure, substandard housing or heightened exposure to natural or manmade disasters, war or conflict, threatens the livelihoods of the poor and drives many in poverty, or traps them there. Such insecurity, combined with a lack of freedom and resources to move, is itself a critical contributor to extreme vulnerability.

65. Lack of participation in governance and accountability is a vital component of multidimensional poverty. The benefits of society go to those who are able to participate in its creation. Poverty undermines participation and dims the voices of the poor, especially where there is a high degree of inequality. Poverty is both a cause and a consequence of multiple human rights deprivations for which, often, no one is held accountable. Participation means ensuring that duty bearers are held responsible and that laws are enforced.

66. Finally, poverty is fundamentally related to sustainability. Economic growth is a necessary engine of poverty reduction. However, the global rise in income and wealth inequality, together with the environmental impacts of economic growth, underscore that economic growth alone is insufficient for inclusive development. Economic growth and finite environmental resources are being directed disproportionately to the wealthy, undermining poverty reduction. At the same time, the waste and by-products of environmentally unfriendly industry and development heavily impact the poor and compound poverty.

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[43] United Nations Development Programme (UNDP), *Human Development Report 2013: The Rise of the South — Human Progress in a Diverse World* (New York, 2013).

[44] *The World's Women 2010: Trends and Statistics* (see footnote 11 above).

[45] B. G. Link and J. Phelan, "Social conditions as fundamental causes of disease", *Journal of Health and Social Behavior*, vol. 35 (1995), pp. 80-94.

67. In responding to the global survey of the Programme of Action beyond 2014, not only did an overwhelming majority of Governments (93 per cent) indicate that they are addressing[46] "the eradication of poverty, with special attention to income generation and employment strategies", but "social inclusiveness, and protection of the poor" were prioritized across numerous segments of the survey. For example, when asked to identify public policy priorities for sustaining family welfare over the next 5-10 years, Governments were most likely to include "social protection of the family" (77 per cent), which captured all priorities pertaining to the provision of social services and/or investments for the fulfilment of basic needs.

68. **States should develop, strengthen and implement effective, integrated, coordinated and coherent national strategies to eradicate poverty and break the cycles of exclusion and inequality as a condition for achieving development, also targeting persons belonging to marginalized or disadvantaged groups, in both urban and rural areas, guaranteeing for all people the chance to live a life free from poverty and to enjoy protection and exercise of their human rights.**

Human rights elaborations since the International Conference on Population and Development

Box 1
Poverty

Intergovernmental human rights outcomes. The General Assembly has adopted a series of resolutions on the relationship between human rights and extreme poverty, including resolution 65/214 on human rights and extreme poverty (2012), in which the Assembly reaffirmed "that extreme poverty and exclusion from society constitute a violation of human dignity and that urgent national and international action is therefore required to eliminate them".

Other soft law. The Guiding Principles on Human Rights and Extreme Poverty (2012) are international global policy guidelines that address the human rights of people living in poverty in accordance with international human rights norms and standards.

The economic and social cost of income and wealth inequality

69. Achieving equal opportunity and equitable outcomes is the basis for sustained economic and social well-being. Expanding the capabilities of diverse people, through better health, education and opportunity, expands the collective pool of creative energy, ideas and contributions in a given society. Technical, economic and social innovations thrive under conditions in which many people have the opportunity to fully participate and succeed in society. The reverse is also true: severe inequalities in access to health, security and high-quality education can prevent large sectors of the population from rising out of poverty and achieving

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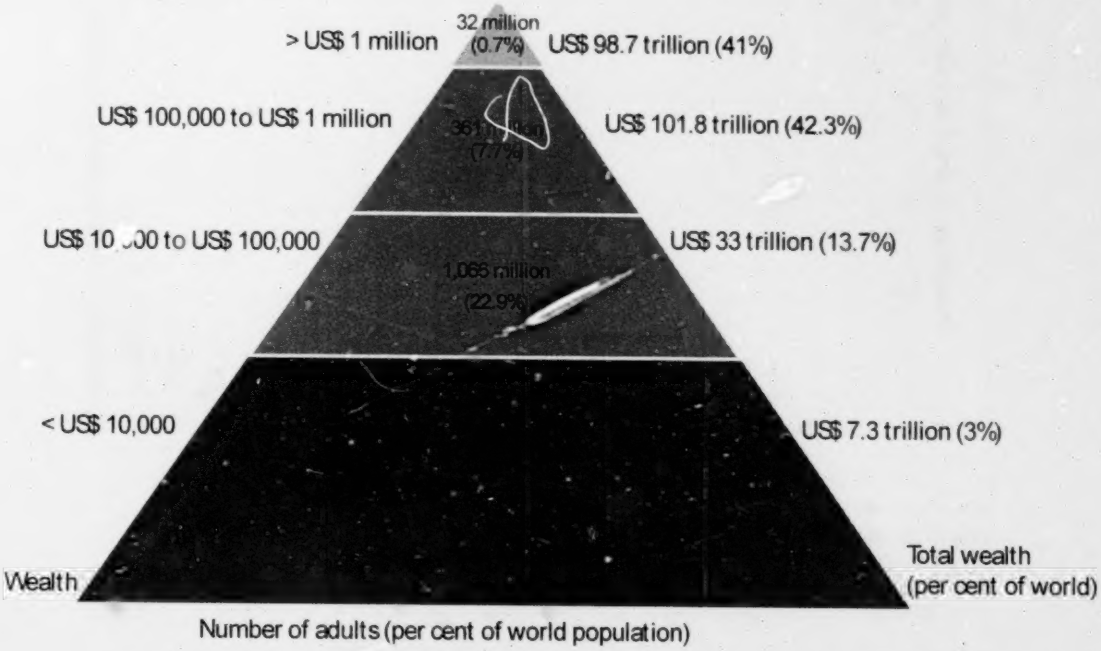
[46] The definition of "addressed" (yes/no), is based on countries reporting three responses to a given issue: [the existence of relevant policy] + [allocation of budget] + [implementation of programmes] during the preceding five years. All three conditions must be met to classify a Government as "addressing" the issue.

social mobility, and such conditions increasingly narrow the selection of persons and ideas that contribute to society.

70. The current distribution of wealth (see figure 2) presents a serious threat to further economic growth, inclusiveness, and both social and environmental sustainability. According to the Credit Suisse Global Wealth Report, global wealth was estimated at US$ 223 trillion in mid-2012. This works out to an estimated US$ 48,500 for each of the world's 4.6 billion adults. However, this figure hides enormous inequalities. Approximately 69 per cent of all adults were found in the lowest wealth category, accounting for only 3 per cent of global wealth. The next category (US$ 10,000 to US$ 100,000) contained 1,066 million adults who owned 13.7 per cent of global wealth. The category from US$ 100,000 to US$ 1 million included 361 million adults, or 7.7 per cent of the total adult population, who commanded 42.3 per cent of global wealth. Finally, the category of those with wealth of more than US$ 1 million included 32 million adults, representing only 0.7 per cent of the global adult population, who commanded 41 per cent of the world's wealth. In short, 8.4 per cent of the adult population in the world commanded 83.3 per cent of global wealth, while almost 70 per cent of adults possessed only 3 per cent of the wealth.

Figure 2
The global wealth pyramid



Source: James Davies, Rodrigo Lluberas and Anthony Shorrocks, Credit Suisse Global Wealth Databook 2013, in Credit Suisse Global Wealth Report 2013, p. 22, available from https://publications.credit-suisse.com/tasks/render/file/?fileID=BCDB1364-A105-0560-1332EC9100FF5C83.

71. Owing to the convergence of mean incomes of developing and developed economies, global income inequality has been falling in recent years, albeit only slightly, and from a very high level. The more recent stabilization and slight

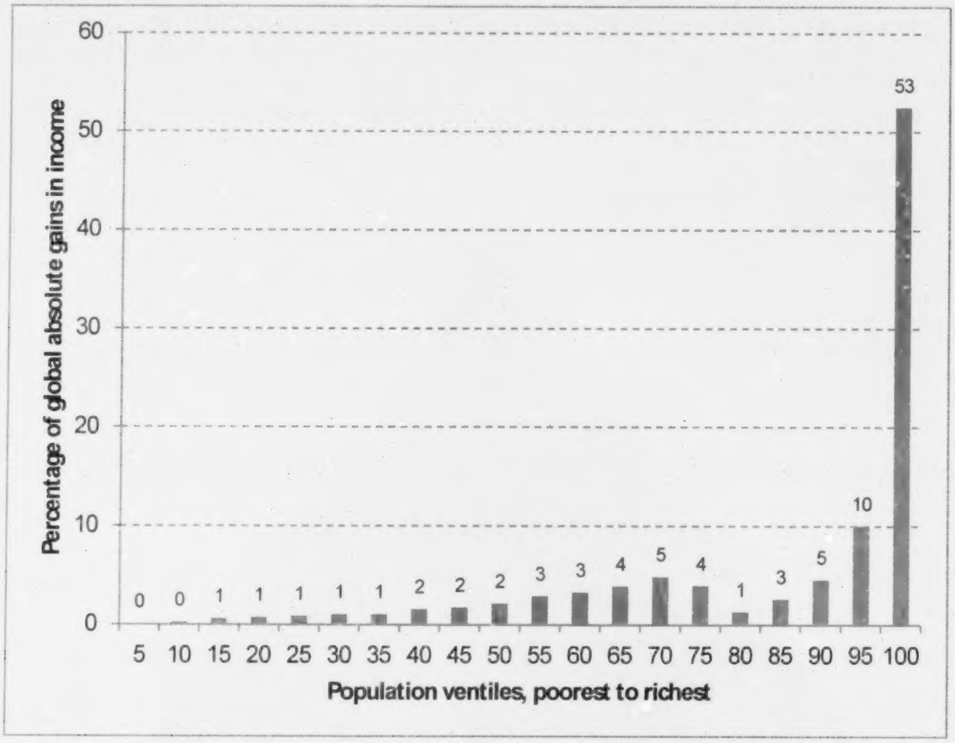
narrowing of global income inequality largely reflect economic growth in China since the 1990s, growth in India, and growth in other emerging and developing economies since 2000.[47] Nevertheless, income inequality within and among many countries has been rising.[48]

72. Figure 3 depicts the unequal distribution of gains in global income from 1988 to 2008. More than half of the gains went to the richest 5 per cent, while 5 per cent or less of global income went to each ventile in the bottom 90 per cent of the population.

Figure 3

Distribution of global absolute gains in income by population ventile, 1988-2008

(Calculated in 2005 purchasing power parity (PPP) international dollars)



Source: Branko Milanovic, "Global income inequality by the numbers: in history and now: an overview", World Bank Policy Research Working Paper No. 6259, November 2012, pp. 12-16, as cited in *World Economic and Social Survey 2013: Sustainable Development Challenges* (United Nations publication, Sales No. E.13.II.C.1).

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[47] Branko Milanovic, "Global income inequality by the numbers: in history and now: an overview", World Bank Policy Research Working Paper No. 6259 (Washington, D.C., World Bank, November 2012), cited in *World Economic and Social Survey 2013: Sustainable Development Challenges* (United Nations publication, Sales No. E.13.II.C.1).

[48] *World Economic and Social Survey 2013: Sustainable Development Challenges* (United Nations publication, Sales No. E.13.II.C.1).

73. Increasing economic inequality is disruptive and highly detrimental to sustainable development. From a social perspective, inequality impedes trust and social cohesion, threatens public health, and marginalizes the poor and the middle class from political influence. Social sustainability, which can be understood as the capacity of a given society to promote innovation and adaptability under changing economic, social and environmental conditions in a manner respectful of human rights, is directly threatened by having a large — and potentially growing — sector of the population caught in "development traps", living day-to-day without real prospects for a better future.

74. Growing inequality also reduces prospects for grappling with emerging environmental crises and rebalancing our economic growth with responsibility for the planet. It has been estimated that 11 per cent of the world's population accounts for half of all emissions, yet it is the poorest segments of the population who are disproportionately affected by natural disasters due to climate change.[49]

75. Given the enormous environmental costs of economic growth under the current development paradigm, the world simply cannot afford the current trajectories of wealth concentration while at the same time sustaining efforts to reduce poverty. Reductions in environmental impact necessary to achieve environmental sustainability only heighten this contradiction.

76. Finally, the social and health consequences of inequality and exclusion not only hinder the human rights-based development championed at the International Conference and Development, but they also have the potential to destabilize societies. In today's globalized world, where information spreads throughout countries and the world in an instant, the increasing concentration of wealth and its links with unemployment, social injustice and powerlessness of millions have become a touchstone for political protests, conflict and instability.

77. **States should accord the highest priority to poverty eradication by ensuring that all persons have equal opportunities to share in the fruits of economic and social development, to find productive employment, and to live in peace and dignity, free from discrimination, injustice, fear, want or disease.**

78. As noted at the outset of this section, economic inequalities are both the cause and the consequence of other social inequalities, including those experienced because of gender, race, disability, age or other dimensions of identity and circumstance. Given the principal message of the International Conference, namely, that investments in individual capability, dignity and freedom are the foundation of shared human well-being and sustainable development, the ensuing parts of this section are devoted to a closer look at the extent to which dignity, human rights and well-being have, or have not, been advanced for women and girls, and for numerous population groups identified in the Programme of Action as experiencing long-standing vulnerability to stigma and discrimination.

B. Women's empowerment and gender equality

79. Discrimination against certain populations is common in many countries, but discrimination against women is universal. Many young women are not empowered in the course of childhood. Instead, they are socialized to embrace subordination to

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[49] The Worldwatch Institute, *State of the World 2013: Is Sustainability Still Possible?* (Washington, D.C., Island Press, 2013).

men and to adopt gender values that hold ideal femininity to be incompatible with independence, power or leadership. In certain regions, women's agency may be further compromised by early or forced marriage, unintended pregnancy and early childbearing (particularly without adequate support from the health system), lack of education, lower wages than men and gender-based violence. The hallmark commitment at the International Conference to women's empowerment was therefore not only the expression of the aspiration for dignity, but pivotal to creating the conditions that will enable half the world's population to have the possibility to define the direction of their lives, expand their capabilities and elaborate their chosen contributions to society.

80. The Programme of Action was historic in drawing attention, long overdue, to the intimate relationship between women's relative freedom with regard to marriage, sexuality and reproduction, their gendered position in society, and their lifetime health and well-being. In the years since 1994, the world has seen an impressive proliferation of national institutions to address women's empowerment and gender equality. These institutions span countries at all income levels and in all regions (see sect. VI.A below).

81. As reported by Governments in the global survey, over 97 per cent of countries worldwide had programmes, policies and/or strategies to address "gender equality, equity and empowerment of women". At least 9 out of every 10 countries, across all regions, had such frameworks in place: 100 per cent of countries in Africa; 100 per cent in Asia; 94 per cent in Europe; 94 per cent in the Americas; and 93 per cent in Oceania.

82. However, only three quarters of responding countries committed themselves to "improving the situation and addressing the needs of rural women" (76 per cent) and to "improving the welfare of the girl child, especially with regard to health, nutrition and education" (80 per cent).

Human rights elaborations since the International Conference on Population and Development

Box 2

Women's empowerment and gender equality

Binding instruments. In 1999, the General Assembly adopted the Optional Protocol to the Convention on the Elimination of All Forms of Discrimination against Women, which enables the Committee on the Elimination of Discrimination against Women to consider communications by individuals and groups alleging that their rights under the Convention have been violated, and created an inquiry procedure that allows the Committee to investigate violations of women's rights in a State party to the Convention. At the regional level, the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa recognizes the importance of women's political, economic and social participation and calls for the elimination of all forms of discrimination against women.

Intergovernmental human rights outcomes. In its resolution 15/23 on the elimination of discrimination against women (2010), the Human Rights Council expressed "concern at the fact that, despite the pledge made at the Fourth World Conference on Women and the review conducted by the General Assembly at its twenty-third special session to modify or abolish remaining laws that discriminate against women and girls, many of those laws are still in force and continue to be applied, thereby preventing women and girls from enjoying the full realization of their human rights".

Other intergovernmental agreements. The Beijing Declaration (1995) reaffirmed the commitment to "[e]nsure the full implementation of the human rights of women and of the girl child as an inalienable, integral and indivisible part of all human rights and fundamental freedoms".

1. Changing patterns in productive and reproductive roles

(a) Changing patterns of employment

83. The gender gap in labour force participation has narrowed slightly since 1990, but women continue to be paid less than men, to be employed more often in the informal sector and in temporary and insecure, and to command less authority. The overall rate of women's participation in the labour force remained generally steady at the global level; however, in the last few years the rate of participation of both women and men showed a slight decline. At the regional level, women's labour force participation has been variable. It increased the most in Latin America and the Caribbean, and decreased slightly in Eastern Europe and much of Asia other than South Asia, where it increased slightly.[50] The labour force participation of women aged 25-54[51] has increased in all regions since 1990 except for Eastern Europe; this is due to declining fertility and a lessening impact of fertility on labour force participation.[52]

84. Women's share in wage employment in the non-agricultural sector and in traditionally male-dominated occupations has increased, although it remained low in jobs associated with status, power and authority. In all regions, women remain significantly underrepresented among business leaders and managers.[53]

85. The gender pay gap is closing slowly, and only in some countries,[50] and women continue to be paid less than men for equal work, They also tend to hold jobs that are less secure and have fewer benefits than those accorded to men, and to be engaged in vulnerable employment (see figure 4), which comprises contributing family workers and own-account workers as opposed to wage and salaried

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[50] *The World's Women 2010: Trends and Statistics* (see footnote 11 above); International Labour Organization (ILO), *Global Employment Trends for Women 2012* (Geneva, International Labour Office, 2012).

[51] This is a more robust indicator that mitigates labour force participation rates that are affected by changing age structures, but this indicator is not available for comprehensive number of countries.

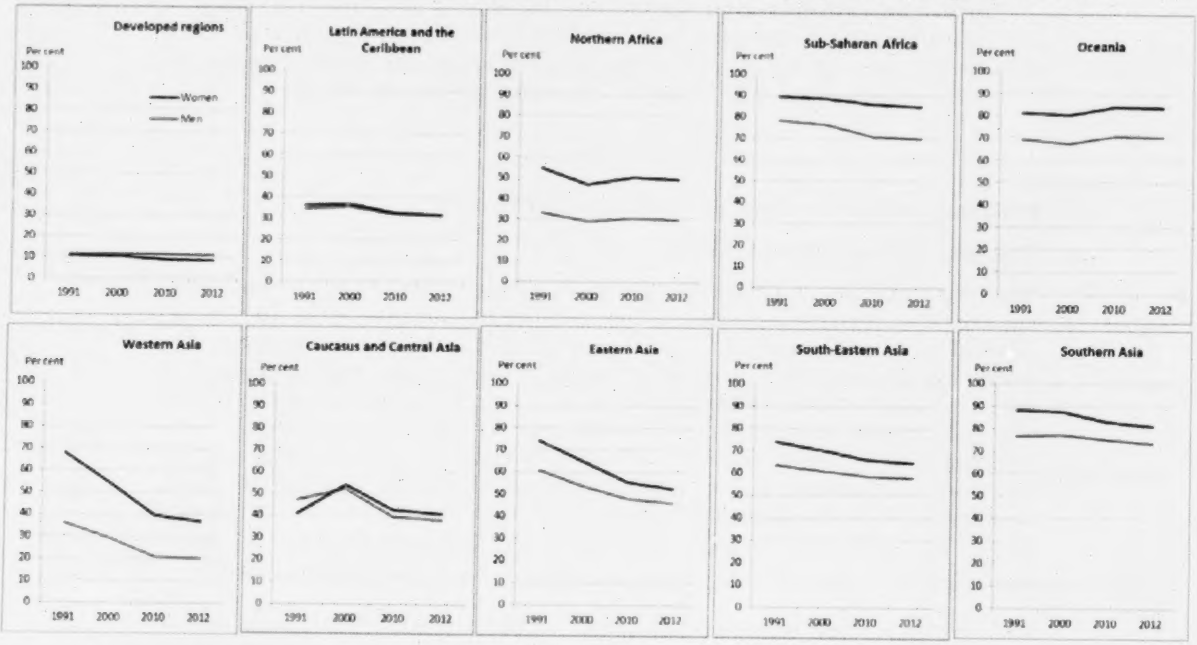
[52] *The World's Women 2010: Trends and Statistics*.

[53] *The World's Women 2010: Trends and Statistics*; see also "Millennium Development Goals, targets and indicators, 2013: statistical tables", available from http://mdgs.un.org/unsd/mdg/Host.aspx?Content=Data/Trends.htm.

workers.[54] Although the overall proportion of total employment that is vulnerable employment declined over the past 20 years, it remains high in many regions outside the developed countries, particularly in sub-Saharan Africa, Oceania, Southern Asia and South-East Asia (see figure 4). Women continue to be more concentrated in vulnerable jobs than men in all but the wealthiest countries. The gender gap is widest in North and sub-Saharan Africa and Western Asia; it decreased in Asia and increased in sub-Saharan Africa.

Figure 4

Proportion of own-account and contributing family workers in total employment by region, 1991-2012



Source: United Nations, *Millennium Development Goals Report 2013*, annex: Millennium Development Goals, targets and indicators, 2013: statistical tables.

86. Since 1995, the participation of women in paid employment has increased substantially, raising the question how paid employment has affected women's overall work burden. Studies undertaken in Africa reveal that time poverty and income poverty may be interrelated and that women in particular suffer from both. In one country, while the average man worked 38.8 hours per week, women on average worked 49.3 hours and at least a quarter of women reported working 70 hours per week, a clear sign that time poverty is a problem;[55] similar patterns have been found in Latin America.[56]

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[54] *The Millennium Development Goals Report 2013*; *The World's Women 2010: Trends and Statistics*; ILO, *Global Employment Trends for Women 2012*.

[55] E. Bardasi and Q. Wodon, "Working long hours and having no choice: time poverty in Guinea", *Feminist Economics*, vol. 16, No. 3 (2010), pp. 45-78.

[56] S. Gammage, "Time pressed and time poor: unpaid household work in Guatemala", *Feminist Economics*, vol. 16, No. 3 (2010), pp. 79-112.

87. The Programme of Action called on Governments to take steps to eliminate inequalities between men and women by:

- Adopting appropriate measures to improve women's ability to earn income beyond traditional occupations, achieve economic self-reliance, and ensure women's equal access to the labour market and social security systems
- Eliminating discriminatory practices by employers against women

88. The Member States participating in the regional operational review conferences acknowledged that increasing women's access to paid employment has many advantages, both for women themselves and for economic development more generally. By pulling women into paid employment, not only does national income rise, but societies can draw more extensively on the many talents and skills women have to offer. Additionally, women's increased engagement with the monetary economy creates a positive feedback loop in terms of job creation.

89. **States should enact or review, strengthen and enforce laws against workplace discrimination against women, guaranteeing women the same access as men to formal and secure employment, with equal pay for equal work.** Guaranteeing equal employment opportunities for women and men advances equality and is also beneficial for economic growth. Gender equality in education, skill development, and equal access to all sectors of employment can result in broad productivity gains and increased profitability; improved well-being of women and their families; and more inclusive institutions and policy choices.[57]

90. Companies that invest in women's employment often find that it benefits their bottom line by improving staff retention, innovation, and access to talent and new markets.[58] A recent report by the International Monetary Fund (IMF) estimates that closing the gender gap in the labour market would raise GDP in the United States of America by 5 per cent, in the United Arab Emirates by 12 per cent and in Egypt by 34 per cent,[59] and that economic benefits of women's empowerment and gender equality are particularly high in rapidly ageing societies, where women's labour force participation can help to offset the impact of an otherwise shrinking workforce.

91. On the issue of enhancing women's income-generation ability, 85 per cent of all countries reported having budgetary policies and programmes to address "increasing women's participation in the formal and informal economy"; the proportion does not vary with the wealth of countries. Eighty-five per cent of countries also reported that they had a law in place (with an enforcement provision) prohibiting gender discrimination at work in hiring, wages and benefits.

(b) Support for working parents

92. The Programme of Action encouraged countries to create policies and programmes to support work-life balance and enable parents to participate in the

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[57] ILO, *Global Employment Trends for Women 2012*; World Bank, *World Development Report 2012. Gender Equality and Development* (Washington, D.C., 2011); International Finance Corporation (IFC), *Investing in Women's Employment: Good for Business, Good for Development* (Washington, D.C., 2013).

[58] IFC, *Investing in Women's Employment*.

[59] K. Elborgh-Woytek and others, "Women, work and the economy: macroeconomic gains from gender equity", IMF Staff Discussion Note, No. SDN/13/10 (Washington, D.C., International Monetary Fund, 2013).

workforce without compromising the well-being of children and households by making it possible, through laws, regulations and other appropriate measures, for women to combine the roles of childbearing, breastfeeding and child-rearing with participation in the workforce.

93. Ninety per cent of countries reporting in the global survey stated that they have a law in place, with an enforcement provision, for paid maternity leave (of any length); however, only 54 per cent have such an instrument in place for paid paternity leave, constituting a major barrier to men's participation in parenting. Europe is the region with the highest proportion of countries with a law guaranteeing paternity-related benefit (81 per cent), followed by the Americas (53 per cent), Africa (52 per cent), Asia (43 per cent) and Oceania (29 per cent).

94. Fewer than half of responding countries reported having enforced laws guaranteeing day-care centres and facilities for breastfeeding mothers in the public (41 per cent) or private sectors (39 per cent). These limitations can make it impossible for women to rejoin the labour market after childbirth, or to breastfeed after doing so, with negative implications for both women's productivity and child health. In fact, only one in four African countries — the region where most of the population growth will occur in the next decades — have laws in place to ensure compatibility between maternal and work responsibilities (25 per cent for both public and private sectors).

95. If a composite indicator is created for the five family-work balance issues described above (promulgated and enforced laws against workplace discrimination against women; facilitating compatibility between labour force participation and parental responsibilities; promulgated and enforced laws that enable maternity leave; promulgated and enforced laws that enable paternity leave; promulgated and enforced laws that facilitate breastfeeding in the workplace), of 113 countries with complete information, only 26, or 19 per cent, have addressed all five dimensions.

96. **States should ensure universal access to paid parental leave for both mothers and fathers, including adoptive parents, and to high-quality infant and childcare for working parents, including extended after-school care; and establish and enforce laws that require that public and private workplaces accommodate the needs of breastfeeding mothers.**

(c) Co-responsibility

97. Women continue to bear most of the responsibilities at home, caring for children and other dependent household members, preparing meals, cleaning or doing other housework. It is estimated that, in all regions, women spend at least twice as much time as men on unpaid domestic work; and when paid and unpaid work are combined together, women's total work hours are longer than men's. Balancing work and family is particularly challenging for employed parents with young children, and often women are the ones to discontinue their employment or take on part-time jobs while their partners keep a full-time job.[60]

98. The Programme of Action recognized that the full participation of and partnership between both women and men is required in productive and reproductive life, including co-responsibility for the care and nurturing of children and maintenance of the household.

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[60] The *World's Women 2010: Trends and Statistics* (see footnote 11 above).

99. Gender equality in the home and the workplace demands changes in the involvement of men and boys in reproductive roles and household chores; without such task shifting, women take on an inordinate double burden of responsibility and are unlikely to realize their full and fair participation in both productive and reproductive life and to enjoy equal status in society.

100. While many countries have made substantial advances in enhancing women's participation in the labour force since 1994, gender inequalities in the balance of work and family life have not garnered the same level of support. For example, fewer than two thirds of countries (64 per cent) reporting to the global survey have addressed the issue of "facilitating compatibility between labour force participation and parental responsibilities", making it easier for women to combine child-rearing with participation in the workforce. This issue has been prioritized by a smaller proportion of countries in the Americas (53 per cent) and in Africa (55 per cent) compared with Asia (74 per cent) or Europe (92 per cent). In fact, a higher proportion of richer countries and countries with slow population growth have addressed these issues compared with poorer countries and countries with rapid population growth.

101. Two thirds of countries reporting to the global survey have "engaged men and boys to promote male participation [and] equal sharing of responsibilities such as care work" during the past five years (63 per cent). Although no major regional variations are observed, grouping countries by income shows that this is a greater concern for high-income countries that are members of the Organization for Economic Cooperation and Development (OECD) (81 per cent), while the proportion of countries addressing this issue in the four other income groups is just above or below the world average (low-income countries: 69 per cent; lower-middle-income countries: 58 per cent; higher-middle-income countries: 57 per cent; high-income non-OECD countries: 67 per cent).

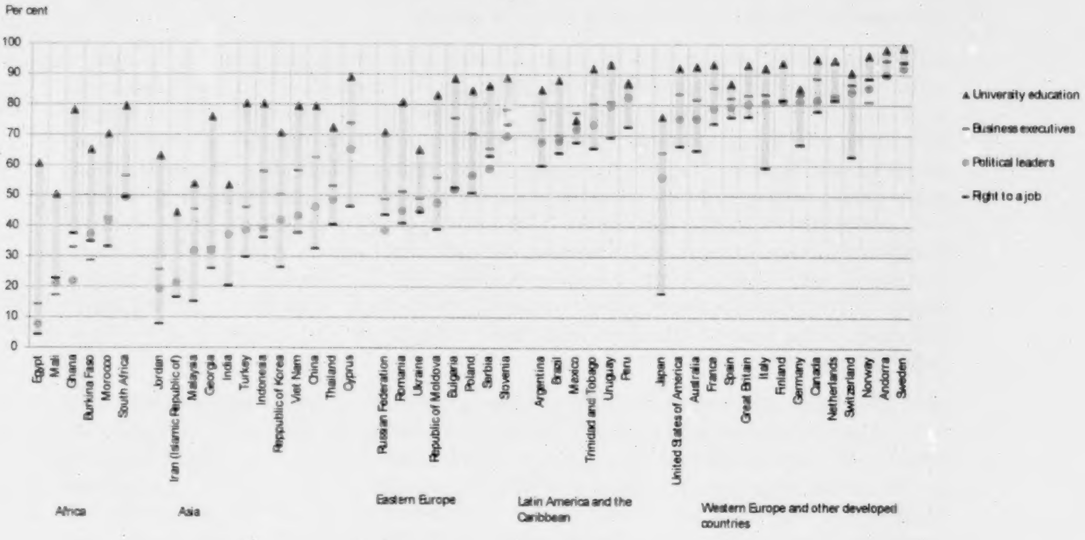
2. Uneven progress in attitudes towards gender equality

102. The majority of the public supports women's empowerment and gender equality in most of the countries for which there are data, but the extent of support depends on the specific gender value under consideration. The most recent round of the World Values Survey, undertaken in 47 countries, provides evidence that public values are most gender equitable with respect to access to higher education, highly variable with regard to men's and women's equal access to jobs, and consistently more modest with regard to women's effectiveness (relative to men's) as leaders in business or politics (see figure 5). Currently, there is a large consensus with regard to the importance of tertiary education for both girls and boys; in most countries, the majority of people no longer believe that a university education makes a difference only for boys. However, with regard to other public spheres, distinct gender roles that give advantage to men are still valued in countries in Africa and Asia and in some of the countries of Eastern Europe. For example, men are considered better business and political leaders by 50 per cent or more of people in almost half of the surveyed countries, with perceptions of male superiority in political leadership more pronounced than in business.

103. The data suggest that values of gender equality have been trending upwards in most countries since the mid-1990s (see figure 5), with the exception of the value "when jobs are scarce, men should have more right to a job than women", which is highly variable between countries and over time.

Figure 5

Support for gender equality in university education, business executives and political leaders and women's equal right to employment by region, 2004-2009



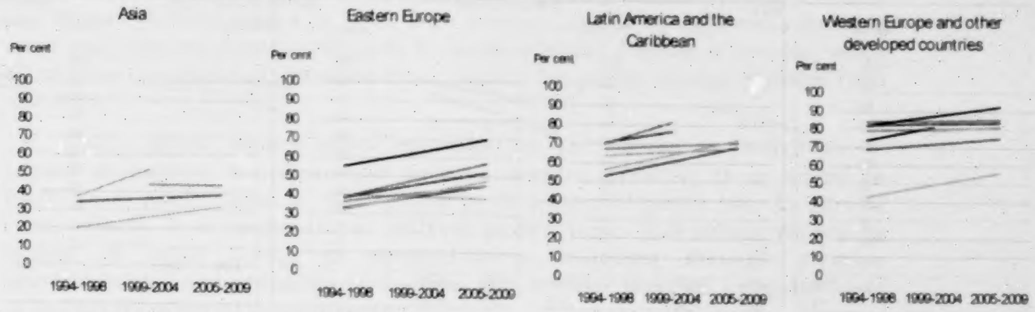
Source: World Values Surveys 2004-2009 data (downloaded and analysed on 20 August 2013).

Note: Support for gender equality is measured as the proportion of respondents who disagree with the following statements: (a) "a university education is more important for a boy than for a girl"; (b) "on the whole, men make better business executives than women do"; (c) "on the whole, men make better political leaders than women do"; and (d) "when jobs are scarce, men should have more right to a job than women".

104. The regional and development gaps in gender values have been getting smaller, as countries in Western Europe and wealthy non-OECD countries have already reached a high degree of social consensus while countries in Latin America and the Caribbean, as well as countries in Eastern Europe, are catching up.

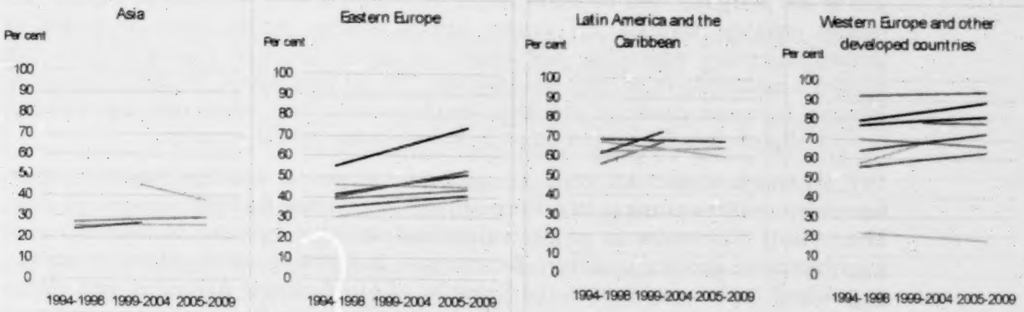
105. Some countries showed no significant change in support for gender equality values. These countries are in all regions, and they vary depending on the issue in question. No progress was observed for one eighth of countries (3 out of 25 with available data) with regard to tertiary education; a quarter of countries (6 out of 25) with regard to political leadership; and a third of countries (8 out of 25) with regard to access to the job market.

Figure 5.a
Support for women as political leaders by region, 2004-2009



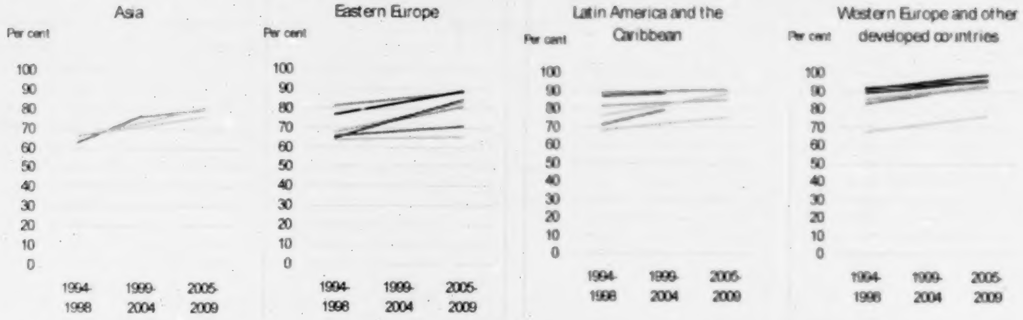
Source: World Values Surveys 2004-2009 data.
Note: Measured as the proportion of respondents who disagree with the following statement: "on the whole, men make better political leaders than women do".

Figure 5.b
Support for gender equality in access to employment by region, 2004-2009



Source: World Values Surveys 2004-2009 data.
Note: Measured as the proportion of respondents who disagree with the following statement: "when jobs are scarce, men should have more right to a job than women".

Figure 5.c
Support for gender equality in access to university education by region, 2004-2009



Source: World Values Surveys 2004-2009 data. (downloaded and analysed 20 August 2013).
Note: Measured as the proportion of respondents who disagree with the following statement: "a university education is more important for a boy than for a girl".

106. There is greater support for gender equality among women than men. This is the case for all four issues explored, and in the majority of countries. The gender gap is not marginal, and becomes larger in countries with less overall support for gender equality. Overall, the gender gap is smaller on the issue of access to tertiary/university education, and larger on men's favoured access to jobs and women's leadership in politics and business. For all four issues, the gap is lowest in Western European countries and other developed countries, where men are as likely, or only slightly less likely, as women to acknowledge gender equality.

107. Although women are stronger supporters of gender equality than men, there have been positive changes in gender attitudes and values for both women and men. The overall differences in gender values and attitudes between women and men have increased in some countries, for example, concerning values related to women as political leaders in Ukraine, the Republic of Moldova and Argentina, and values related to education in the Russian Federation. In those cases, the proportion of women who support gender equality has increased significantly, while the proportion of men remained at the same, lower, levels as in the previous surveys. Conversely, in other countries, men progressed more than women, for example, regarding values related to tertiary education in Turkey and Brazil. While women remain stronger in their support for gender equality, in some cases men are getting closer to the higher level of support shared by women.

108. Younger generations also tend to be more positive towards gender equality than older cohorts, although the intergenerational gap is significant only in a few countries. In about half of the countries surveyed in 2005, younger generations showed significantly stronger support for gender equality in political and managerial leadership and higher education. With regard to the right to a job, young people strongly supported gender equality in about three quarters of countries.

109. Countries in Western Europe have the highest intergenerational consensus with regard to politics, while countries in Eastern Europe and Africa have the highest intergenerational consensus with regard to the right to a job.

110. The results suggest that changes in attitudes and values regarding gender are taking place across whole societies over time, rather than only among younger generations. For some countries with available data on trends, the cross-sectional

differences over 10 years were larger than differences between older cohorts of over 50 years of age and younger cohorts of 15-29 years. This is the case of some Eastern and Western European countries. For example, regarding attitudes towards women and men as political leaders in 2005, there were no significant differences between older and younger cohorts in Bulgaria, Romania, Ukraine, Finland or Sweden, while all of those countries had shown increased support for gender equality between 1995 and 2005.

111. **States should ensure equal opportunities for women to contribute to society as leaders, managers and decision makers, granting them access to positions of power equal to that of men in all sectors of public life. As part of these efforts, it is important to address public views and values regarding sexism or other forms of discrimination, including through creative communication and education campaigns, and monitor these on a regular basis as indicators of social development.**

3. Gender-based violence

112. An estimated one in three women worldwide report that they have experienced physical and/or sexual abuse, mostly at the hands of an intimate partner, making this form of violence against women and girls one of the most prevalent forms of human rights violations worldwide.[61]

113. The first multi-country study (2005) estimating the extent of domestic violence against women, found that the proportion of adult women who had ever suffered physical violence by a male partner ranged widely across the 10 countries studied, from 13 per cent to 61 per cent.[62] The proportion of women who had experienced severe physical violence by a male partner, defined as "being hit with a fist, kicked, dragged, threatened with a weapon or having a weapon used against her", ranged from 4 per cent to 49 per cent, with most countries falling between 13 per cent and 26 per cent.[63] The first global and regional prevalence estimates (2013) of sexual and physical intimate partner violence and non-partner sexual violence showed that 30 per cent of women worldwide aged 15 and older who had ever had a partner had experienced some form of intimate partner violence, with as many as 38 per cent of women in some regions having experienced such violence.[64]

114. Metrics to measure non-partner sexual violence are less clearly defined, highlighting a general lack of data on that form of violence. Current global estimates are that 7 per cent of women have experienced sexual violence by someone other than an intimate partner. Combined estimates show that 36 per cent of women globally have experienced either intimate partner violence, non-intimate partner violence, or both forms of gender-based violence.[65]

115. A recent (2013) United Nations multi-country study on men and violence in Asia and the Pacific found that nearly half of the 10,000 men interviewed reported using physical and/or sexual violence against a female partner; across the sites, the

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[61] WHO, *Global and Regional Estimates of Violence against Women: Prevalence and Health Effects of Intimate Partner Violence and Non-Partner Sexual Violence* (Geneva, 2013).

[62] C. Garcia-Moreno and others, *WHO Multi-Country Study on Women's Health and Domestic Violence against Women* (see footnote 12 above).

[63] Ibid.

[64] WHO, *Global and Regional Estimates of Violence against Women.*

[65] Ibid.

proportion of men using violence ranged from 26 per cent to 80 per cent.[66] Nearly a quarter of the men interviewed reported committing rape against a woman or girl, 10-62 per cent across the sites. Men begin perpetrating violence at young ages, with half of those who admitted to rape reporting a first incident when they were teenagers, and some even younger than 14. Of those men who admitted to rape, the vast majority (72-97 per cent in most sites) had experienced no legal consequences, confirming that impunity remains a serious issue in the region. Across all sites, the most common motivation that men cited for rape related to sexual entitlement, that is the belief that men have a right to have sex with women regardless of whether they consent; over 80 per cent of men who admitted to rape in sites in rural parts of two countries gave this response. Overall, 4 per cent of all respondents said that they had participated in gang rape of a woman or girl, 1-14 per cent across the sites. These are the first data from such a large sample of men on the perpetration of gang rape.[67]

116. The health effects of intimate partner violence are substantial and contribute, directly and indirectly, to numerous negative health outcomes among women and their children. Thirty-eight per cent of all murders of women globally are committed by intimate partners. Beyond non-fatal and fatal injuries, experiences of intimate partner violence among women are associated with an increased risk of HIV and other sexually transmitted infections. Further, women who have experienced sexual or physical intimate partner violence show higher rates of induced abortion and poor birth outcomes, including low birth weight and preterm births. Gender-based violence also has serious short- and long-term social and economic costs for societies, including direct costs through health expenditures; indirect economic costs on workforce participation, missed days of work and lifetime earnings; as well as indirect costs to the long-term health and well-being of children and other people living in a violent household.[68]

117. The Demographic and Health Surveys programme collected data in 12 countries on attitudes towards "wife-beating" at a minimum of two points in time, to determine the percentage of men and women aged 15-49 who agreed that a husband/partner is justified in hitting or beating his wife/partner for at least one of the following reasons: if she burns the food, argues with him, goes out without telling him, neglects the children or refuses sexual relations. As displayed in figure 6, there has been a measurable decline in the proportion of males who endorse any of these justifications for this particular form of physical intimate partner violence. While these trends suggest positive change in men's respect for women's dignity, it must

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[66] E. Fulu and others, *Why Do Some Men Use Violence against Women and How Can We Prevent It? Quantitative Findings from the United Nations Multi-Country Study on Men and Violence in Asia and the Pacific* (Bangkok, UNDP, UNFPA, UN-Women and UNV, 2013).

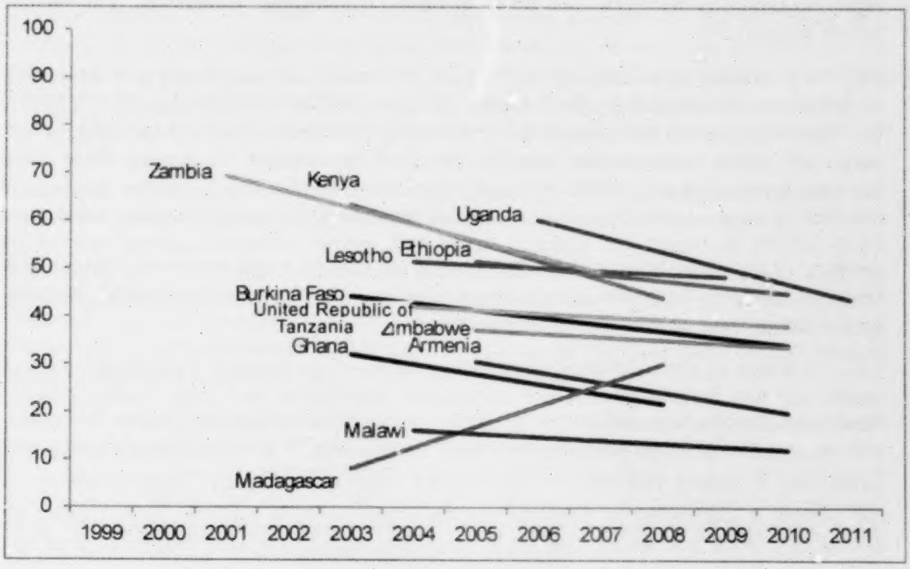
[67] Ibid.

[68] R. K. Jewkes and others, "Intimate partner violence, relationship power inequity, and incidence of HIV infection in young women in South Africa: a cohort study", *The Lancet*, vol. 376, No. 9734, pp. 41-48; A. R. Morrison and M. B. Orlando, "The costs and impacts of gender-based violence in developing countries: methodological considerations and new evidence", Working Paper No. 36151 (Washington, D.C., World Bank, 2004); H. A. Weiss and others, "Spousal sexual violence and poverty are risk factors for sexually transmitted infections in women: a longitudinal study of women in Goa, India", *Sexually Transmitted Infections*, vol. 84, No. 2 (2008), pp. 133-139; WHO, *Global and Regional Estimates of Violence against Women*.

be noted that in five countries, more than 40 per cent of respondents still endorsed justifications for domestic violence.[69]

Figure 6

Trends in men's attitudes towards "wife beating"



Sources: Demographic and Health Surveys, all countries with available data for at least two time points, available from www.measuredhs.com (accessed on 15 November 2013).

118. Similar trends are noted in women's attitudes, with an overall decline between survey time points. Despite positive trends, however, as many as 70 per cent of women surveyed in some countries continue to agree that wife-beating is justified under certain circumstances.[70]

119. Government accountability and community-supported policies to promote women's empowerment and gender equality are key to preventing and responding to gender-based violence, alongside social and economic interventions that challenge social norms and promote women's economic rights and gender empowerment.[71] The Commission on the Status of Women at its fifty-seventh session adopted agreed conclusions on the elimination and prevention of all forms of violence against women (E/2013/27, chap. I, sect. A) in which the Commission urged Governments to strengthening legal and policy frameworks and monitoring and to ensure

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[69] The 12 countries with available data are Armenia, Burkina Faso, Ethiopia, Ghana, Kenya, Lesotho, Madagascar, Malawi, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe; see Demographic and Health Surveys data (www.measuredhs.com/); and UNICEF Childinfo database (www.childinfo.org/attitudes.html).

[70] Ibid.

[71] G. Sen, "*Sexual and reproductive health and rights in the post 2015 development framework*", provisional discussion paper prepared for the International Conference on Population and Development Beyond 2014 International Conference on Human Rights, held in the Netherlands from 7 to 10 July 2013; WHO, *Global and regional estimates of violence against women* (see footnote 61 above).

accountability, while addressing structural causes of violence and promoting multisectoral responses.

120. WHO guidelines urge a strengthened multipronged health system response to intimate partner and sexual violence, improving access to critical treatment services such as emergency contraception, abortion in cases of pregnancy resulting from rape, prophylaxis for HIV and other sexually transmitted infections, and mental health support.[72]

121. In a number of resolutions the Security Council has recognized and responded to the extent of violence against women and girls, including resolution 2122 (2013), in which the Council recognized the importance of humanitarian aid including a full range of health services for women affected by conflict, including those who become pregnant as a result of rape; resolution 1325 (2000) on the impact of conflict on women and their role in conflict resolution and peacebuilding; resolution 1820 (2008) in which the Council noted that sexual violence against women in conflict could constitute a war crime; and resolution 1888 (2009) in which the Council explicitly charged peacekeeping missions with the job of protecting women and children from sexual violence in conflict.

122. Violence against children takes many forms, is perpetrated by both adults and peers, and can lead to greater risk of suicide, depression and other mental illness, substance abuse, a reduced ability to avoid other violent relationships and, for some, a heightened risk of perpetrating violence themselves.[73] While girls are especially vulnerable to sexual violence and abuse, new multi-country data[74] draw attention to the violent experiences of boys during childhood, which are too often treated as normal for boys but which can have long-term effects no less traumatic than for girls.

123. Recent data from six countries[75] affirm the longstanding observations that men are more likely to use violence against women and children if they lack gender-equitable attitudes, witnessed or experienced household violence during childhood, are under acute economic stress, or are experiencing the disruptions of displacement or conflict.[76]

124. Psychologists suggest that acute fear, prevalent during war or conflict, may be temporarily dissipated for some people by perpetrating aggression against others. Such a response can also lead to heightened non-combatant violence. Rape and other forms of sexual violence are used as tactics of war, but their incidence also

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[72] WHO, *Responding to Intimate Partner Violence and Sexual Violence against Women: WHO Clinical and Policy Guidelines* (Geneva, 2013).

[73] See, inter alia, the report of the independent expert for the United Nations study on violence against children, 2006 (see A/61/299); WHO and International Society for Prevention of Child Abuse and Neglect, *Preventing Child Maltreatment: A Guide to Taking Action and Generating Evidence* (Geneva, World Health Organization, 2006).

[74] Representing surveys conducted in Brazil, Chile, Croatia, India, Mexico and Rwanda. Findings from the International Men and Gender Equality Survey (IMAGES), presented by Gary Barker at the dialogue on men and boys, masculinity and sexual and reproductive health and rights, organized by the United Nations Population Fund in New York on 23 September 2013.

[75] G. Barker and others, *Evolving Men: Initial Results from the International Men and Gender Equality Survey (IMAGES)* (Washington, D.C., International Center for Research on Women; Rio de Janeiro, Instituto Promundo, January 2011).

[76] Ibid.

increases within the non-combatant population during war-related instability and conflict.[77]

125. Recent data from eastern Democratic Republic of the Congo, which has experienced sustained internecine violence for over a decade, demonstrate that almost half (48 per cent) of male non-combatants reported using physical violence against women; 12 per cent acknowledged having carried out partner rape; and 34 per cent reported perpetrating some kind of sexual violence. In addition, of all men and women surveyed, 9 per cent of adult men had been victims of sexual violence, and 16 per cent of men and 26 per cent of women had been forced to watch sexual violence.[78] All available evidence suggests that the consequences of such violence can be serious and long term,[79] and several small-scale efforts are under way in the eastern Democratic Republic of the Congo to try and address the emotional trauma of victims and their families, as well as physical scarring.[80]

126. Of all the issues related to the Programme of Action listed in the global survey, "ending gender-based violence" was one of those addressed by the highest proportion of Governments (88 per cent). Regionally, this issue was addressed by 94 per cent of Governments in Africa, 87 per cent in the Americas, 90 per cent in Asia, 82 per cent in Europe and 77 per cent in Oceania.

127. With regard to legal frameworks aimed at preventing and addressing abuse, neglect and violence, only 87 per cent of countries reported in the global survey that they had promulgated and enforced laws criminalizing rape and other forms of sexual exploitation, and only 53 per cent of countries had promulgated and enforced laws criminalizing marital rape (Africa: 39 per cent; Americas: 57 per cent; Asia: 48 per cent; Europe: 75 per cent; Oceania: 62 per cent).

128. Seventy-three per cent of countries had promulgated and enforced laws criminalizing intimate partner violence, an issue that has been prioritized in the Americas (88 per cent) and Europe (84 per cent) in contrast to Asia (61 per cent), Africa (68 per cent) and Oceania (71 per cent).

129. In relation to the criminalization of sexual exploitation of young people, particularly girls, 83 per cent of countries reported that they had promulgated and

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[77] Presentation by Ernesto Mujica at the dialogue on men and boys, masculinity and sexual and reproductive health and rights, organized by the United Nations Population Fund in New York on 23 September 2013.

[78] H. Slegh and others, *Gender Relations, Sexual Violence and the Effects of Conflict on Women and Men in North Kivu, Eastern Democratic Republic of Congo: Preliminary Results of the International Men and Gender Equality Survey (IMAGES)* (Cape Town, Sonke Gender Justice Network; Washington, D.C., Promundo-US, 2012).

[79] E. Kinyanda and others, "War related sexual violence and its medical and psychological consequences as seen in Kitgum, Northern Uganda: a cross-sectional study", *BMC International Health and Human Rights 2010*, vol. 10, November 2010; J. Ward and M. Marsh, "Sexual violence against women and girls in war and its aftermath: realities, responses and required resources", briefing paper prepared for the Symposium on Sexual Violence in Conflict and Beyond, held in Brussels from 21 to 23 June 2006; A. O. Longombe, K. M. Claude and J. Ruminjo, "Fistula and traumatic genital injury from sexual violence in a conflict setting in Eastern Congo: case studies", *Reproductive Health Matters*, vol. 16, No. 31 (2008), pp. 132-141; I. Joachim, "Sexualised violence in war and its consequences", in Medica Mondiale, ed., *Violence against Women in War: Handbook for Professionals Working with Traumatized Women* (Frankfurt, Mabuse, 2005), pp. 63-110.

[80] Panzi Hospital, *Annual Activity Report: Panzi Hospital 2012*. Available from www.panzihospital.org/wp-content/uploads/2013/03/0823-Panzi_ENG_v9.pdf.

enforced laws, and 77 per cent had promulgated and enforced laws preventing the use of children in pornography.

130. If a composite indicator is calculated for the six legal dimensions cited above, results show that only 28 per cent of countries have promulgated and enforced laws in all cases. Almost half of the countries in Europe (48 per cent) and Oceania (46 per cent) have done so, but a smaller share of countries in Africa (26 per cent), Asia (15 per cent) and the Americas (14 per cent) have done so. **States should adopt and implement legislation, policies and measures that prevent, punish and eradicate gender-based violence within and outside the family, as well as in conflict and post-conflict situations. Laws that exonerate perpetrators of violence against women and girls, including provisions that allow them to evade punishment if they marry the victim, or are the partners or husbands of the victim, should be revised. Sexual violence should also be eliminated from post-conflict amnesty provisions within the framework of strengthened legislation and enforcement to end impunity.**

131. **States should enhance their capacity to recognize and prevent violence, ensure the provision of services that can mitigate the consequences of violence and enable the full rehabilitation of those who experience it. In addition, States should strengthen routine monitoring and extend research into important unaddressed issues such as the number of people living in conditions of sustained fear; violence within schools, prisons and the military; the causes and consequences of violence; and the effectiveness of interventions and of laws and systems for the protection and recovery of victims and/or survivors.**

132. **States should further ensure that all victims/survivors of gender-based violence have immediate access to critical services, including 24-hour hotlines; psychosocial and mental health support; treatment of injuries; post-rape care, including emergency contraception, post-exposure prophylaxis for HIV prevention and access to safe abortion services in all cases of violence, rape and incest; police protection, safe housing and shelter; documentation of cases, forensic services and legal aid; and referrals and longer-term support.**

Priorities of civil society organizations regarding gender-based violence

133. A recent survey (2013) among 208 civil society organizations[81] in three regions (the Americas, Africa and Europe) that work in the area of gender-based violence found that in Africa, 23 per cent of civil society organizations cited "gender norms and male engagement" as the number one top priority issue for public policy for the next 5-10 years. In the Americas and Europe, 31 per cent and 21 per cent of civil society organizations respectively identified the "development of programmes, policies, strategies, laws and the creation of institutions to eradicate gender-based violence" as a priority. Finally, the "elimination of all forms of violence", including sexual violence, rape, domestic violence and femicide, among others, is also consistently mentioned by civil society organizations across all regions as the number one top priority issue for public policy for the next 5-10 years (Africa: 20 per cent; the Americas: 22 per cent; Europe: 26 per cent).

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[81] Only one representative of each civil society organization was allowed to respond to this survey, irrespective of the size and coverage of the organization. Several civil society organizations that responded to the survey have a national, regional and/or global scope with large beneficiary populations.

Human rights elaborations since the International Conference on Population and Development

Box 3

Gender-based violence

Binding instruments. In the years following the International Conference on Population and Development, gender-based violence emerged as a prominent human rights issue, particularly in regional binding instruments, including: The Inter-American Convention on the Prevention, Punishment and Eradication of Violence against Women (1994), which has been ratified by most States members of the Organization of American States (OAS); the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (1995); and the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (2011), which will enter into force once it has been ratified by 10 States.

Intergovernmental human rights outcomes. The Human Rights Council has adopted a series of resolutions on intensifying efforts to eliminate all forms of violence against women, including resolution 14/12 on accelerating efforts to eliminate all forms of violence against women: ensuring due diligence in prevention (2010).

Other soft law. Concluding observations of various treaty monitoring bodies require States to take measures to prevent sexual violence, provide rehabilitation and redress to victims of sexual violence, and prosecute offenders.[82]

4. Female genital mutilation/cutting

134. Female genital mutilation/cutting refers to all practices that include the "partial or total removal of the external female genitalia or other injury to the female genital organs for non-medical reasons".[83] The practice can have both short- and long-term health consequences and risks, which increase in accordance with the severity of the procedure. Female genital mutilation/cutting offers no known health benefits to women and girls.[84]

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[82] See concluding observations of the Committee on the Rights of the Child following the consideration by the Committee of the third periodic report of Lebanon (CRC/C/42/3, para. 429 (d)); concluding observations of the Committee on the Elimination of Discrimination against Women following the consideration by the Committee of the combined fourth, fifth and sixth periodic report of the United Republic of Tanzania (A/63/38, part two, chap. IV.B, para. 120); concluding observations of the Committee against Torture following the consideration by the Committee of the second periodic report of Costa Rica (A/63/44, para. 40 (19)).

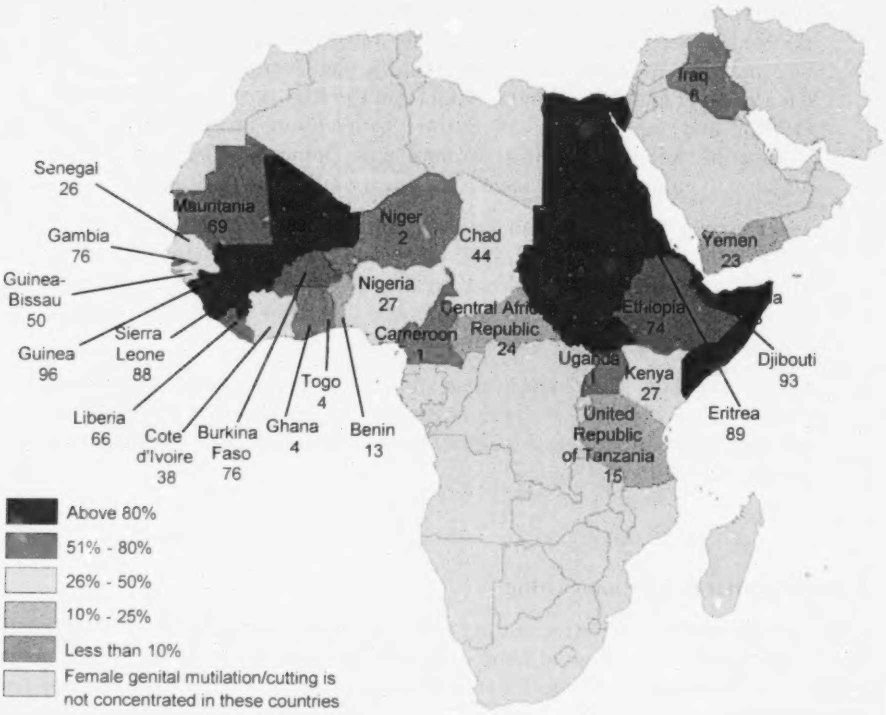
[83] WHO, "Female genital mutilation", Factsheet No. 241 (February 2014); available from www.who.int/mediacentre/factsheets/fs241/en/; WHO, *Eliminating Female Genital Mutilation: An Interagency Statement* (Geneva, 2008); available from www.un.org/womenwatch/daw/csw/csw52/statements_missions/Interagency_Statement_on_Eliminating_FGM.pdf.

[84] WHO, *Eliminating Female Genital Mutilation: An Interagency Statement*.

135. An estimated 125 million women and girls worldwide live with the consequences of female genital mutilation/cutting, with approximately 3 million girls, the majority under age 15, at risk of undergoing the procedure each year. It is practiced widely in more than 29 countries, predominately in the western, eastern and north-eastern regions of Africa and in some Arab States (see figure 7).[85]

Figure 7

Percentage of girls and women aged 15-49 who have undergone female genital mutilation/cutting by country


Senegal 26
Gambia 76
Guinea-Bissau 50
Guinea 96
Sierra Leone 88
Liberia 66
Cote d'Ivoire 38
Burkina Faso 76
Ghana 4
Togo 4
Benin 13
Mauritania 69
Niger 2
Chad 44
Nigeria 27
Cameroon 1
Central Afri
Republic 24
Iraq 8
Yemen 23
Ethiopia 74
Djibouti 93
Eritrea 89
Uganda 1
Kenya 27
United Republic of Tanzania 15
Above 80%
51% - 80%
26% - 50%
10% - 25%
Less than 10%
Female genital mutilation/cutting is not concentrated in these countries

Source: UNICEF, *Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change* (New York, 2013).

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[85] United Nations Children's Fund (UNICEF), *Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change* (New York, 2013); *UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change — Annual Report 2012* (New York, 2013); WHO, *Eliminating Female Genital Mutilation: An Interagency Statement* (2008).

136. Socioeconomic factors such as educational attainment and household income influence the prevalence of and attitudes towards female genital mutilation/cutting within countries, while, owing to increased migration, the prevalence of the practice among women and girls living outside their countries is also on the rise.[86]

137. Since the joint statement issued by UNICEF, the United Nations Population Fund (UNFPA) and WHO in 1997,[87] great efforts have been made to eliminate female genital mutilation/cutting, and indeed the past decades have seen increased international attention and resources devoted to ending the practice. Numerous international and regional human rights instruments protect the rights of women and girls and call for the eradication of female genital mutilation/cutting. It is a violation of the rights of the child, the right of all persons to the highest attainable standard of health, the right to be free from torture and cruel, inhuman or degrading treatment, and is a form of gender inequality and discrimination against women.[88] However, its persistence and scale, coupled with statistical projections that by 2030, 20.7 million girls born between 2010 and 2015 will likely experience some form of female genital mutilation/cutting,[89] further highlight the urgent need to intensify, expand and improve efforts to accelerate the current annual rate of reduction and eliminate the practice in less than a generation. The new inter-agency statement issued by a wider group of United Nations agencies in 2008 calls for increased support, advocacy and resources for the elimination of female genital mutilation/cutting at the community, national and international levels.[88]

138. The global survey revealed that 46 per cent of countries have promulgated and enforced laws protecting the girl child against harmful practices, including female genital mutilation/cutting, with 66 per cent of countries in Africa and just 26 per cent of countries in Asia having done so.

139. Punitive laws that criminalize female genital mutilation/cutting are unlikely to succeed on their own, and must be accompanied by culturally sensitive public awareness and advocacy campaigns that create sustained change in cultural and community attitudes. Community-led approaches endorsed by national and local leaders will be critical to creating the sustained behavioural change necessary to protect the rights of women and girls by ending the practice.[88] Indeed, those communities that have employed a process of collective and participatory decision-making have been able to abandon it.[90]

140. **States should develop, support and implement comprehensive and integrated strategies for the eradication of female genital mutilation/cutting, including the training of social workers, medical personnel, community and religious leaders and relevant professionals, and ensure that they provide competent, supportive services and care to women and girls who are at risk of, or who have undergone, female genital mutilation/cutting, and establish formal**

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[86] UNICEF, *Female Genital Mutilation/Cutting: A Statistical Overview and Exploration of the Dynamics of Change*; WHO, *Eliminating Female Genital Mutilation: An Interagency Statement* (2008); P. S. Yoder, N. Abderrahim and A. Zhuzhuni, *Female Genital Cutting in the Demographic and Health Surveys: A Critical and Comparative Analysis*, DHS Comparative Reports No. 7 (Calverton, Maryland, United States of America, ORC Macro, 2004).

[87] WHO, *Female Genital Mutilation: A Joint WHO/UNICEF/UNFPA Statement* (Geneva, 1997).

[88] WHO, *Eliminating Female Genital Mutilation: An Interagency Statement* (2008).

[89] See UNFPA, MDG5b+Info database (www.devinfo.org/mdg5b/).

[90] *UNFPA-UNICEF Joint Programme on Female Genital Mutilation/Cutting: Accelerating Change — Annual Report 2012.*

mechanisms for reporting to the appropriate authorities cases in which they believe women or girls are at risk, and ensure that health professionals are able to recognize and address health complications arising from the practise.

Human rights elaborations since the International Conference on Population and Development

Box 4
Female genital mutilation/cutting

Binding instruments. The Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (1995; entry into force 2005) states, "States Parties shall prohibit and condemn all forms of harmful practices which negatively affect the human rights of women. ... States Parties shall take all necessary legislative and other measures to eliminate such practises, including: ... prohibition through legislative measures backed by sanctions, of all forms of female genital mutilation." Article 38 of the Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (2011; not in force) states that "Parties shall take the necessary legislative or other measure to ensure that the following intentional conducts are criminalized: (a) excising, infibulating or performing any other mutilation to the whole or any part of a woman's labia majora, labia minora or clitoris; (b) coercing or procuring a woman to undergo any of the acts listed in point (a); (c) inciting, coercing or procuring a girl to undergo any of the acts listed in point (a)."

Intergovernmental human rights outcomes. The General Assembly has adopted several resolutions on eliminating harmful practices, including female genital mutilation/cutting, including milestone resolution 67/146 on intensifying global efforts for the elimination of female genital mutilation (2012).

5. Government priorities: gender equality and women's empowerment

Economic empowerment and employment	71 per cent of Governments
Political empowerment and participation	59 per cent of Governments
Elimination of all forms of violence	56 per cent of Governments
Gender norms and male engagement	22 per cent of Governments
Work-life balance	7 per cent of Governments

141. Promoting and enabling the "economic empowerment" of women was the priority most frequently mentioned by at least two thirds of countries, in four of the five regions: Africa (67 per cent), Asia (78 per cent), Europe (79 per cent) and Oceania (71 per cent). In the Americas, it was the second most frequently mentioned priority (59 per cent of Governments), following "elimination of all forms of violence". These numbers are in keeping with the widespread recognition that

women's participation in the workplace drives economic growth and development, a phenomenon that has contributed to the recent economic growth in many Asian countries.

142. "Political empowerment and participation" was a priority for two thirds of Governments across Africa (63 per cent), Asia (66 per cent) and Oceania (64 per cent); in Europe and the Americas the issue was a priority for 48 per cent and 53 per cent of Governments, respectively. It was notable that "political empowerment and participation of women" was prioritized by only 45 per cent of Governments of high-income non-OECD countries and 41 per cent of high-income OECD countries. It was a higher priority within other income groups; among low-, lower-middle and upper-middle income countries it was prioritized by 62 per cent, 67 per cent and 62 per cent of Governments, respectively.

143. The low level of support for the political empowerment of women among wealthy non-OECD and wealthy OECD countries may reflect different underlying values. The highest proportion of parliamentary seats held by women is in high-income OECD countries, suggesting that the political participation of women is well advanced and may not be seen as demanding government intervention. In contrast, the lowest proportion of seats are in high-income non-OECD countries, suggesting relatively lower support for women's political leadership, which may reflect the fact that these countries have experienced very rapid economic development that has outpaced social and political change.

144. Globally, the third most frequently cited priority for gender equality and women's empowerment, mentioned by 56 per cent of countries, was the "elimination of all forms of violence".[91] Among countries in the Americas, this was the priority that was mentioned most often, by 69 per cent of Governments, well above the global average. According to WHO, while the lifetime incidence of partner and non-partner physical and sexual violence is highest in Africa, a smaller proportion of countries in the region prioritized this issue (49 per cent) compared with the Americas (69 per cent), Europe (69 per cent) and Oceania (57 per cent).

145. "Gender norms and male engagement" was a priority for only 22 per cent of Governments globally, and was most frequently included by Governments in Europe (34 per cent). This issue was not prioritized by Governments of most low-income and lower middle-income countries, only 15 per cent and 14 per cent of which, respectively, included it. "Addressing son preference" was prioritized by only three countries (Armenia, China, India), countries where the sex ratio is significantly skewed.

146. In contrast to the shared global priority of promoting the economic participation of women, "work life balance"[92] was mentioned as a priority by only 7 per cent of countries worldwide, most of them in Europe. Globally, it appears that the inclusion of women in the workplace is recognized as an obvious step forward; however, holistic policies that include parental (maternity and paternity) leave and quality childcare will be necessary to ensure the well-being of children and families, and to avoid the overburdening of women.

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[91] Comprising all priorities addressing the elimination of all forms of violence against any and all persons, including gender-based violence, sexual violence (rape), domestic violence, trafficking, femicide, slavery and forced sterilization.

[92] Comprising all priorities that address facilitating and ensuring balance in the role of women in the home and workplace, and preservation of the family.

147. **States should initiate national campaigns, including through information and education curricula, and enhance the ability of the education system, both formal and informal, and community groups to eliminate sexism, including violence against women and girls, and promote the participation of men and boys and equal sharing of responsibility, including through the establishment of special schools for men and boys and other community-based institutions, to enable awareness, exposure and behaviour change.**

C. Adolescents and youth

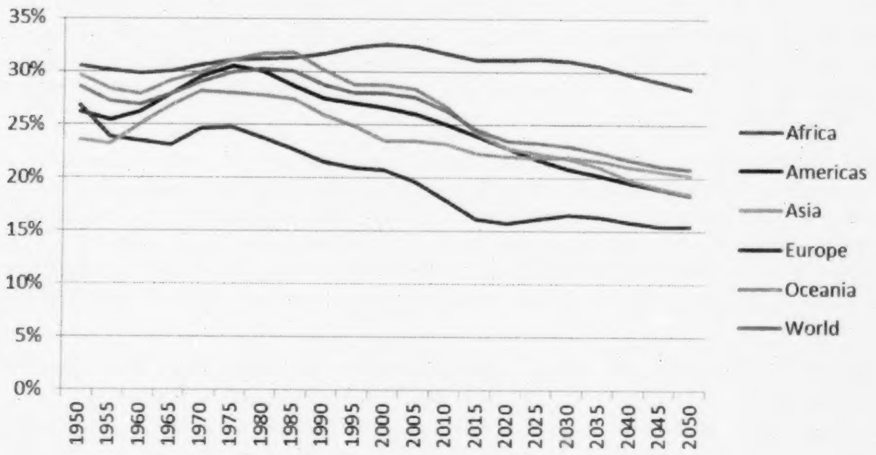
1. The demographic importance of young people

148. Demographic changes in the past decades have led to the largest generation of young people (aged 10-24 years) in the world today, comprising adolescents (aged 10-19 years) and youth (aged 15-24 years). In 2010, 28 per cent of the global population was between 10 and 24, slightly higher than the proportion in Asia, and more than 31 per cent of the population of Africa (see figure 8). While this proportion will decline in most regions in the coming 25 years, it will remain above 20 per cent in all regions except Europe until 2035, and above 30 per cent in Africa until 2035.[93]

Figure 8

Trends and projections in the proportion of young people (10-24 years), worldwide and by region, 1950-2050

(Medium fertility variant)



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[93] *World Population Prospects: The 2012 Revision* (see footnote 7 above).

Figure 8.a

Trends and projections in the proportion of young people (10-24 years) in Africa, by subregion, 1950-2050

(Medium fertility variant)

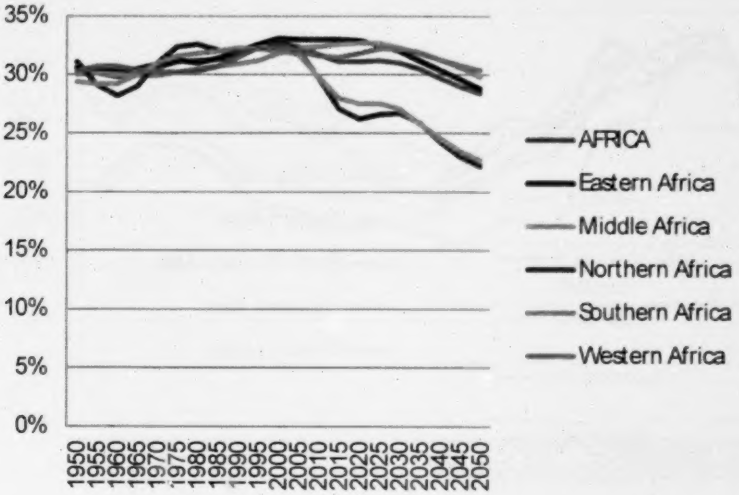


Figure 8.b

Trends and projections in the proportion of young people (10-24 years) in the Americas, by subregion, 1950-2050

(Medium fertility variant)

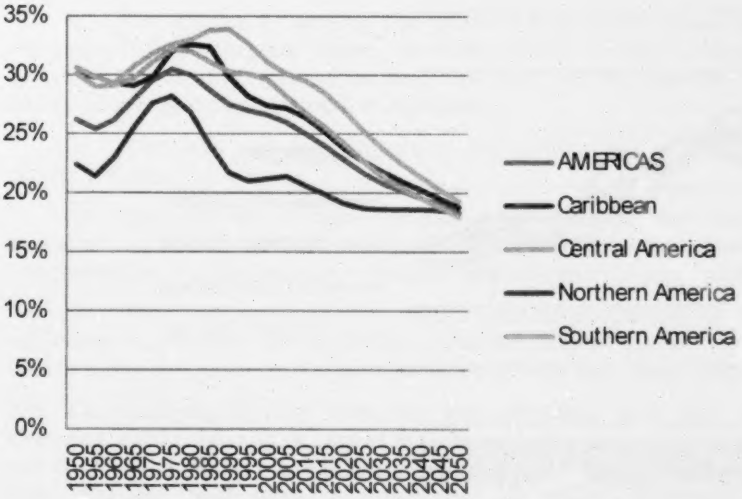


Figure 8.c

Trends and projections in the proportion of young people (10-24 years) in Asia, by subregion, 1950-2050

(Medium fertility variant)

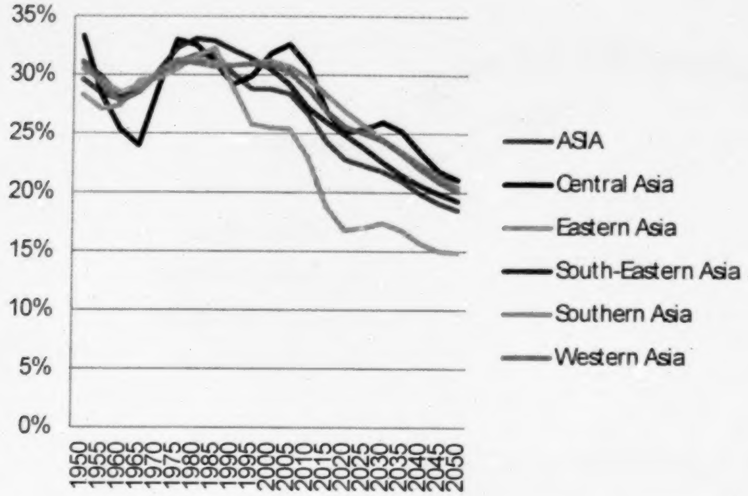


Figure 8.d

Trends and projections in the proportion of young people (10-24 years) in Europe, by subregion, 1950-2050

(Medium fertility variant)

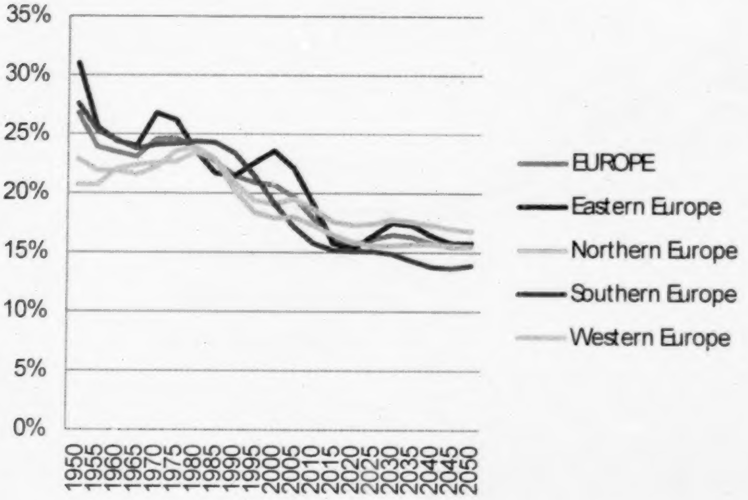
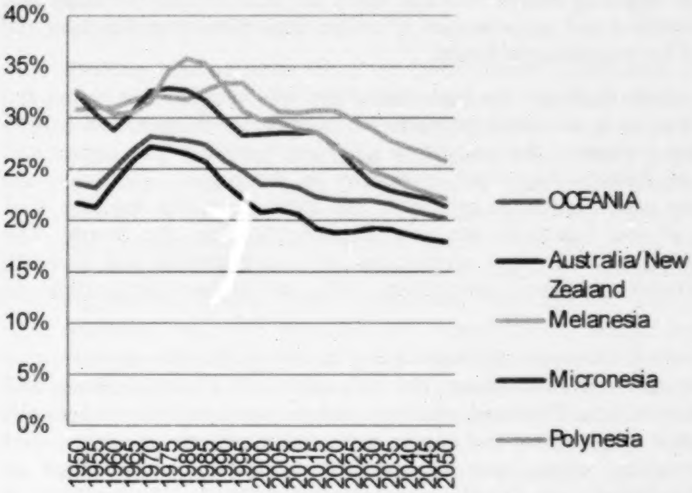


Figure 8.e

Trends in the proportion of young people (10-24 years) in Oceania, by subregion, 1950-2050

(Medium fertility variant)



Source: *World Population Prospects: The 2012 Revision*, November 2013 (ST/ESA/SER.A/336).

149. The centrality of adolescents and youth to the development agenda in the coming two decades is not however because of their numbers in absolute terms,[94] but rather because of four crucial conditions:

(a) The decline in fertility that followed their births means that they must become self-supporting and thrive, for there will be no larger, younger cohort to support them as they themselves age, and they can be expected to live to an advanced age, given increasing life expectancy;

(b) They will also need to support the existing and growing population of elderly persons;

(c) The majority of this cohort is growing up in poor countries, where education and health systems are of poor quality, reproductive choice and health are not guaranteed, good jobs are not abundant and migration is constrained;

(d) They have expectations — higher than the generations before them — for self-direction, freedom and opportunity. The information age has taught them their human rights and given them a broader vision of what their lives could be.

150. The declining fertility rates are also providing low- and middle-income countries with a window of opportunity because the proportion of the population that is of young working age is historically high, and these cohorts can, if provided with learning and work opportunities, jump-start economic growth and development. Therefore, as acknowledged in Commission on Population and Development resolution 2012/1 on adolescents and youth, the well-being and the

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[94] Every cohort ahead of them is the largest of that age group that there has ever been, i.e. the world is currently home to the largest cohort of 40-year olds, 50-year olds, 60-year olds, and so on.

positive social participation of this cohort of adolescents and youth hinges on the commitments of Governments to protect their human rights, develop their capabilities, secure their sexual and reproductive health and rights, prepare them for productive and creative activities and reward them for their labours. Investments in human development targeting adolescents and youth are most critical to ensure that they have the capabilities and opportunities to define their futures, and to spur the innovations needed for a sustainable future.

151. Subregional trends highlight the high proportion of young people across the subregions of Africa, with declining proportions in only Northern and Southern Africa. In Asia, the decline in the proportion of young people began earlier and proceeded faster in Eastern Asia than elsewhere in the region. Similarly, the proportion of young people declined rapidly in the 1980s in North America, and other subregions of the Americas are now converging with the North. The subregions of Europe all have low proportions of young people and Oceania displays wide variations between subregions, with the highest proportions in Melanesia.

152. For youth overall, Governments responding to the global survey prioritize economic empowerment and employment (70 per cent), and social inclusion and education (both 56 per cent). These priorities underscore the intersections between the right to productive employment and decent work and education, training, social integration and mobility, taking into account gender equality, as affirmed in Commission on Population and Development resolution 2012/1. In addition, a number of intergovernmental outcomes, including the World Programme of Action for Youth to the Year 2000 and Beyond, resolution 2012/1 and the regional review outcomes, as well as the multi-stakeholder declaration adopted at the Global Youth Forum held in Bali, Indonesia, highlight the importance of the full and effective participation of young people, as well as the importance of investing in young people as key agents of development and social change.

153. Countries that will host a large youth cohort over the next two decades have in the past five years addressed the needs of their adolescent and youth populations, in particular with regard to job creation and access to sexual and reproductive health services ("creating employment opportunities for youth", 94 per cent; "ensuring the same rights and access to sexual and reproductive health services, including HIV prevention", 94 per cent (see sect. III.D of the present report on sexual and reproductive health and rights and lifelong health for young people). A high percentage also have "addressed the violence, exploitation and abuse" (81 per cent), and "instituted concrete procedures and mechanisms for participation" (81 per cent). "Addressing the adverse effects of poverty on adolescents and youth" is the issue addressed by the smallest proportion of countries (75 per cent), but this proportion is still higher than that observed for any ageing-related issue.

Human rights elaborations since the International Conference on Population and Development

Box 5

Adolescents and youth

Binding instruments. Since the International Conference on Population and Development, regional youth charters, including the Ibero-American Convention on the Rights of Youth (2005; entry into force 2008) and the African Youth Charter (2006; entry into force 2009) promote a broad range of rights for young people. The African Youth Charter provides a framework for youth empowerment, strengthening youth's participation and partnership in development. Specific articles in the Charter affirm rights related to, inter alia, non-discrimination; freedom of movement, expression, thought and association; development and participation; education and skill development; employment; health; and peace and security. The Ibero-American Convention recognizes the right of all youth aged 15-24 to the full realization of civil, political, economic, social and cultural rights and recognizes youth as key actors in development. The Convention recognizes youth rights related to, inter alia, peace, non-discrimination, gender equality, family, life, personal integrity, participation, education, sexual education, health, work and working conditions, housing and a healthy environment. Internationally, through the Optional Protocol to the Convention on the Rights of the Child on the sale of children, child prostitution and child pornography (2000; entry into force 2002) States parties commit, at a minimum, to ensure that such acts "are fully covered under its criminal or penal law, whether such offences are committed domestically or transnationally or on an individual or organized basis".

2. Child, early and forced marriage

154. Denial of the human rights of a child by the practice of child, early and forced marriage is a violation that remains commonplace in many countries and most regions worldwide, even where laws forbid it. Vulnerability to child, early and forced marriage is related to extreme poverty, the low status of women and community vulnerability, as much as to cultural norms. If current trends continue, by 2020, an additional 142 million girls will be married before their eighteenth birthday.[95]

155. Girls living in rural areas of the developing world tend to marry or enter into union at twice the rate of their urban counterparts (44 per cent and 22 per cent, respectively). Girls with a primary education are twice as likely to marry or enter into union as those with a secondary or higher education. However, those with no education are three times more likely to marry or enter into union before age 18 as those with a secondary or higher education. Furthermore, more than half (54 per cent) of girls in the poorest quintile are child brides, compared with only 16 per cent of girls in the richest quintile.[95]

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[95] UNFPA, *Marrying Too Young: End Child Marriage* (see footnote 5 above).

156. As of 2010, 158 countries have a legal age of marriage of 18 years. Nevertheless, for the period 2000-2011, an estimated 34 per cent of women aged 20 to 24 in developing regions had been married or in union before age 18; further, an estimated 12 per cent had been married or in union before age 15.[95]

157. The global survey shows that only 51 per cent of countries have "addressed child marriage/forced marriage" during the past five years, reflecting probably that this practice is not a problem worldwide. When analysis was confined to the 41 "priority countries" in which marriage before age 18 affects more than 30 per cent of girls, 90 per cent of reporting countries had addressed this issue. Yet three of the poorest countries with high rates of child marriage (affecting 39-75 per cent of girls) had not addressed it, and 11 of the 41 priority countries did not provide a response to this question.

158. **States should preserve the dignity and rights of women and girls by eradicating all harmful practices, including child, early and forced marriage, through integrated multisectoral strategies, including the universal adoption and enforcement of laws that criminalize marriage before the age of 18, and through widespread campaigns to create awareness around the harmful health and life consequences of early marriage, supporting national targets and incentives to eliminate this practice within a generation.**

Human rights elaborations since the International Conference on Population and Development

Box 6

Child, early and forced marriage

Binding instruments. Reinforcing pre-1994 obligations enshrined in international human rights law, regional instruments include the Protocol to the African Charter on Human and Peoples' Rights on the Rights of Women in Africa (1995; entry into force 2005), which requires signatory States to ensure that the "minimum age for marriageable women shall be 18 years". The Council of Europe Convention on Preventing and Combating Violence against Women and Domestic Violence (2011; not in force) requires States to "take the necessary legislative or other measures to ensure that the intentional conduct of forcing an adult or child to enter into a marriage is criminalized".

Intergovernmental human rights outcomes. The Human Rights Council adopted its landmark resolution 24/23 on strengthening efforts to prevent and eliminate child, early and forced marriage: challenges, achievements, best practices and implementation gaps (2013).

Other soft law. Through general comments and recommendations, treaty monitoring bodies have agreed that 18 is the appropriate minimum age for marriage and that States should enact legislation to increase the minimum age for marriage to 18, with or without parental consent.[96]

3. Adolescent births, and the mediating role of female education

159. Worldwide, more than 15 million girls aged 15 to 19 years give birth every year,[97] with about 19 per cent of young women in developing countries becoming pregnant before they turn 18.[98] A significant proportion of adolescent pregnancies result from non-consensual sex, and most take place in the context of early marriage.[99] Pregnancies occurring at young ages have greater health risks for mother and child, and many girls who become pregnant drop out of school or are dismissed from school, drastically limiting their future opportunities, their future earnings, and both their own health and the health of their children.[100] Globally, adolescent birth rates are highest in poor countries, and in all countries they are clustered among the poorest sectors of society, compounding the risk of poor maternal outcomes for both mother and child.[101]

160. Adolescent birth rates have been declining from 1990 to 2010 across countries in all income groups and regions. Higher secondary school enrolment among those aged 15-19 is associated with lower adolescent birth rates (see figure 9). While greater literacy among young women is associated with lower birth rates in all regions, this pattern is less evident in countries in the Americas, which are characterized by high adolescent fertility rates despite high rates of enrolment in education. Indeed, Latin America has the second highest adolescent fertility rate in the world, after sub-Saharan Africa, and secondary school enrolment does not have the same impact on youth fertility in Latin America as it does in other regions.

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[96] Committee on the Elimination of Discrimination against Women, general recommendation 21 on equality in marriage and family relations (see A/49/38, chap. I, sect. A); Committee on the Rights of the Child, general comment No. 4 (2003) on adolescent health and development in the context of the Convention on the Rights of the Child (see A/59/41, annex X).

[97] *The Millennium Development Goals Report 2013* (see footnote 4 above).

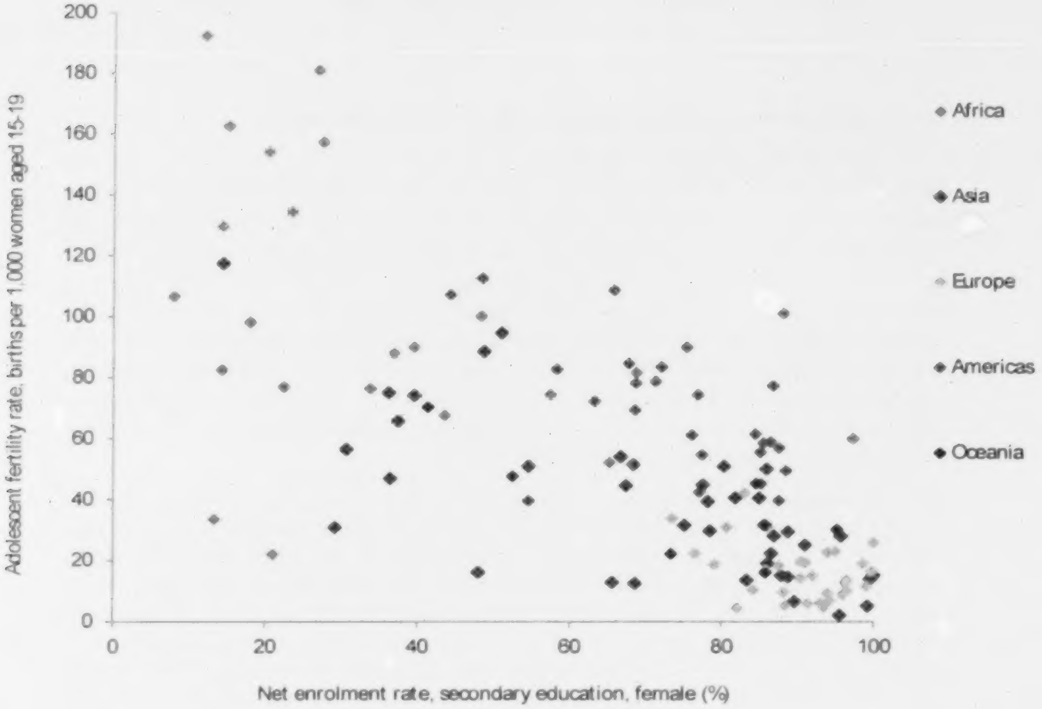
[98] *State of World Population 2013: Motherhood in Childhood — Facing the Challenge of Adolescent Pregnancy* (United Nations publication, Sales No. E.13.III.H.1).

[99] K. G. Santhya, "Early marriage and sexual and reproductive health vulnerabilities of young women: a synthesis of recent evidence from developing countries", *Current Opinion in Obstetrics and Gynecology*, vol. 23, No. 5 (2011), pp. 334-339.

[100] C. B. Lloyd and B. Mensch, "Marriage and childbirth as factors in dropping out of school: an analysis of DHS data from sub-Saharan Africa", *Population Studies*, vol. 62, No. 1 (2008), pp. 1-13; K. G. Santhya and others, "Associations between early marriage and young women's marital and reproductive health outcomes: evidence from India", *International Perspectives on Sexual and Reproductive Health*, vol. 36, No. 3 (2010), pp. 132-139.

[101] UNFPA, *How Universal is Access to Reproductive Health? A Review of the Evidence* (New York, 2010).

Figure 9
Adolescent fertility rate and net secondary education female enrolment rate by region, 2005-2010



Source: *World Population Prospects: The 2012 Revision*, November 2013 (ST/ESA/SER.A/336); and United Nations Educational, Scientific and Cultural Organization (UNESCO), Institute for Statistics, Data Centre, Custom Table, available from http://stats.uis.unesco.org/unesco/TableViewer/document.aspx?ReportId=136&IF_Language=eng&BR_Topic=0.

Note: Adolescent fertility rates are period estimates for the period 2005-2010. Net secondary education female enrolment rates reflect the latest available point estimate for the period 2005-2010.

161. Education of all children increases their capacity to participate socially, economically and politically, but the education of girls leads to special benefits for girls themselves, their families and communities. When girls are educated it reduces the likelihood of child marriage and delays childbearing, leading to healthier birth outcomes. Female education is consistently associated with greater use of family planning, more couple communication about family planning and lower overall fertility.[102] A recent analysis in East Africa found that temporal fertility trends across demographic and health survey waves were associated with changes in female educational attainment, and there was an association between the proportion

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[102] T. Castro Martin, "Women's education and fertility: results from 26 demographic and health surveys", *Studies in Family Planning*, vol. 26, No. 4 (1995), pp. 187-202; S. J. Jeejeebhoy, *Women's Education, Autonomy, and Reproductive Behaviour: Experience from Developing Countries* (Oxford, Clarendon Press, 1995).

of females having no education and stalled fertility declines in Kenya, the United Republic of Tanzania, Uganda and Zimbabwe.[103]

162. Researchers have presented theories and evidence to explain why greater female education leads to lower fertility, showing that education affects girls in numerous critical domains that each affect fertility:[104] education expands opportunities and aspirations for work outside the home, it enhances girls' social status and alters the types of men they marry,[105] it increases their bargaining power within marriage,[106] increases their use of health services, and enhances the health and survival of their children.[107] Greater educational attainment also shapes attitudes of both girls and boys to gender equality, i.e., their gender values, with greater education leading to more positive attitudes towards gender equality among both males and females.[108]

163. Comprehensive sexuality education, as part of in- and out-of-school education, is recognized as an important strategy that empowers young people to make responsible and autonomous decisions about their sexuality and sexual and reproductive health. Evidence also suggests that rights-based and gender-sensitive comprehensive sexuality education programmes can lead to greater gender equality. The Commission on Population and Development, in its resolutions 2009/1 and 2012/1, for example, called on Governments to provide young people with comprehensive education on human sexuality, sexual and reproductive health, and gender equality to enable them to deal positively and responsibly with their sexuality.

164. Only 40 per cent of all countries have addressed "facilitating school completion for pregnant girls". The Americas is the only region where a higher proportion of Governments (67 per cent) reported policies, budgets and implementation measures; in Europe and Asia only 29 per cent and 21 per cent of countries, respectively, reported addressing it. Proportions remain very similar if

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[103] A. C. Ezeh, B. U. Mberu and J. O. Emina, "Stall in fertility decline in Eastern African countries: regional analysis of patterns, determinants and implications", *Philosophical Transactions of The Royal Society, Biological Sciences*, vol. 364, No. 1532 (September 2009).

[104] I. Diamond, M. Newby and S. Varle, "Female education and fertility: examining the links", in *Critical Perspectives on Schooling and Fertility in the Developing World*, C. Bledsoe and others, eds. (Washington, D.C., National Academies Press, 1999), pp. 23-48.

[105] A. M. Basu, "Women's education, marriage and fertility in South Asia: do men really not matter?", in *Critical Perspectives on Schooling and Fertility in the Developing World*, C. Bledsoe and others, eds. (Washington, D.C., National Academies Press), pp 267-286.

[106] S. Kishor and L. Subaiya, *Understanding Women's Empowerment: A Comparative Analysis of Demographic and Health Surveys (DHS) Data*. DHS Comparative Reports No. 20 (Calverton, Maryland, Macro International, 2008).

[107] See, for example, D. M. Cutler and A. Lleras-Muney, "Education and health: evaluating theories and evidence", in *Making Americans Healthier: Social and Economic Policy as Health Policy*, R. F. Schoeni and others, eds. (New York, Russell Sage Foundation, 2008), pp. 29-60; E. Gakidou and others, "Increased educational attainment and its effect on child mortality in 175 countries between 1970 and 2009: a systematic analysis", *The Lancet*, vol. 376, No. 9745 (18 September 2010), pp. 959-974; S. Desai and S. Alva, "Maternal education and child health: is there a strong causal relationship?", *Demography*, vol. 35, No. 1 (1998), pp. 71-81.

[108] R. Inglehart and P. Norris, *Rising Tide: Gender Equality and Cultural Change around the World* (Cambridge, United Kingdom, Cambridge University Press, 2003), p. 226; M. van Egmond and others, "A stalled revolution? Gender role attitudes in Australia, 1986-2005", *Journal of Population Research*, vol. 27, No. 3 (2010), pp. 147-168.

countries are grouped by income level. Support for this issue in Latin America and the Caribbean underscores the relatively high adolescent fertility rate in the region.

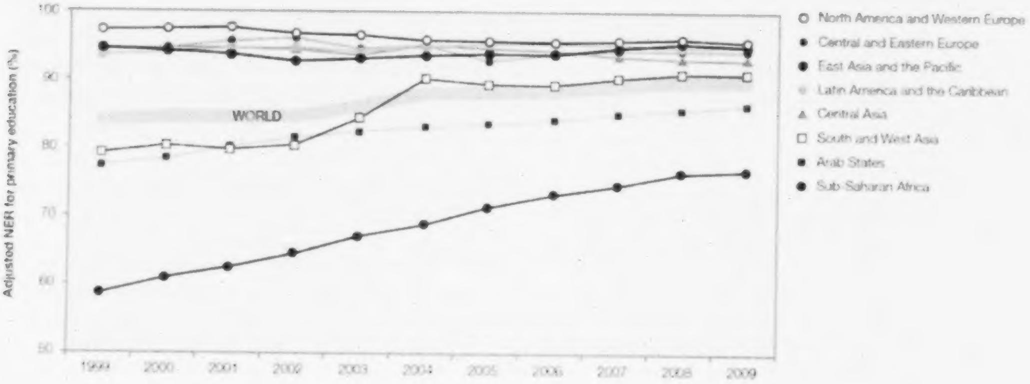
165. **States should implement their commitments to promote and protect the rights of girls by enacting and implementing targeted and coordinated policies and programmes that concretely address: (a) ensuring gender parity in access to school; (b) providing comprehensive sexuality education; (c) reducing adolescent pregnancy; (d) enabling the reintegration of pregnant girls and young mothers into education at all levels, with a view to empowering the girl child and young women to achieve their fullest potential; and (e) eliminating of harmful traditional practices such as child, early and forced marriage and female genital mutilation/cutting.**

4. Uneven progress in education

166. Over the past 15 years the number of children who are attending primary school worldwide has increased to an extraordinary degree, with global enrolment now reaching 90 per cent. However, attaining universal primary education by 2015 is far from certain, and large geographic disparities persist. Primary school enrolments have increased most dramatically in West and South Asia, the Arab States and in sub-Saharan Africa, but because of low starting levels (approximately 60 per cent) in Africa at the turn of the millennium, nearly one in four primary school-aged children in sub-Saharan Africa is still out of school (see figure 10).

Figure 10

Adjusted net enrolment rate for primary education by region, 1999-2009



Source: UNESCO Institute for Statistics. *Global Education Digest 2011: Comparing Education Statistics Across the World*, figure 1, citing UNESCO Institute for Statistics database and statistical table 3. Available from http://www.uis.unesco.org/Library/Documents/global_education_digest_2011_en.pdf.

Note: East Asia and the Pacific and South and West Asia are UNESCO Institute for Statistics estimates based on data with limited coverage for the reference year, produced for specific analytical purposes.

167. Primary completion rates have risen along with overall enrolments, globally as high as 88 per cent in 2009 and ranging from 67 per cent in sub-Saharan Africa to 100 per cent in Latin America and the Caribbean. The largest gains over the last

decade have been in sub-Saharan Africa, South and West Asia and the Arab States.[109]

168. Numerous inequalities nevertheless persist with respect to gender, residence (urban versus rural) and household wealth. Girls have been the main beneficiaries of the trend towards higher gross enrolment ratios,[110] with girls' enrolment increasing at a faster rate than that of boys, and nearly two thirds of countries (128 out of 193) reported in 2012 that they had achieved gender parity in primary schools. However, boys continue to benefit from greater access, as reported by 57 of the 65 countries that have not achieved gender parity in primary education.[111]

169. The global survey found that during the past five years, 82 per cent of countries had addressed the issue of "ensuring equal access of girls to education at all levels", and 81 per cent had addressed "keeping more girls and adolescents in secondary school". When countries are grouped according to income, there are no major differences in the proportion of countries that addressed ensuring equal access; however, keeping girls in secondary school is a policy that is budgeted for and implemented by a higher proportion of poor countries than rich countries.

170. Rural versus urban inequalities persist in school attendance. Lower overall attendance is clearly driven by lower attendance in rural areas, with the largest shortfalls in Africa and Asia. The majority of countries have urban-rural differentials that are close to parity, or between parity and 1.5, but a small group of countries have more severe urban-rural differentials coinciding with net attendance rates of 60 per cent or less.

171. Among the 81 countries with available data, primary school attendance is higher in rural areas than in urban areas in only 12 countries in the Americas, Asia and Europe. However, the urban-rural differential is small in all those cases (less than 5 per cent), and most countries already present primary school net attendance rates higher than 90 per cent, with the exception of Ukraine (73 per cent) and Bangladesh (86 per cent).

172. In nearly half of 162 countries with comparable data, boys and girls do not have an equal chance of completing primary education. Girls generally lag behind boys, though not in all countries. As with enrolment, the largest gains in completion between 1999 and 2009 were observed among girls (see figure 11), yet completion rates are still generally lower for girls. Primary school completion rates increased to 87 per cent for girls overall in the same period, close to the 90 per cent rate for boys. Regionally, South and West Asia saw the greatest relative gains for girls.[111]

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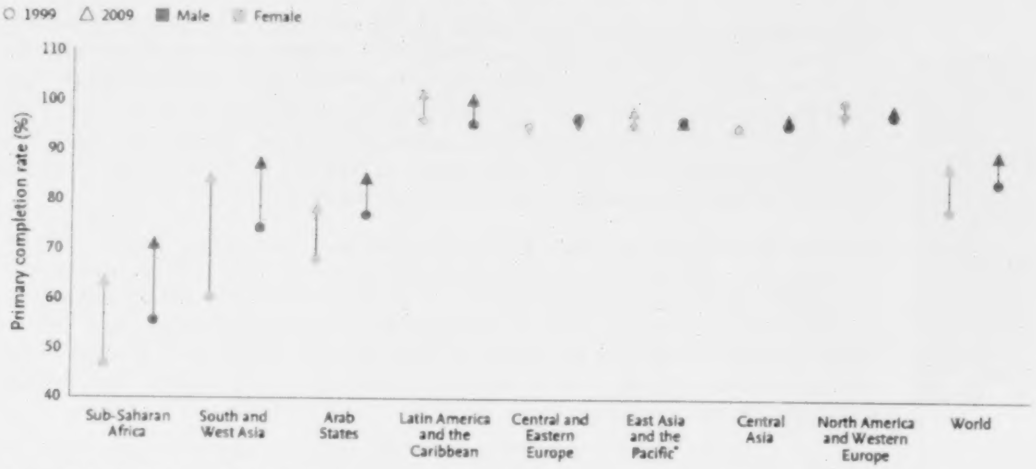
[109] UNESCO, *World Atlas of Gender Equality in Education* (see footnote 5 above), pp. 48-49 and 54.

[110] The gross enrolment ratio is the total enrolment in a specific level of education, regardless of age, expressed as a percentage of the eligible official school-age population corresponding to the same level of education in a given school year. The gross enrolment ratio can exceed 100 per cent if there are significant numbers of under- or over-age children enrolled in primary schools. (See UNESCO Institute of Statistics, *Education Indicators: Technical Guidelines* (November 2009), p. 9; and *World Atlas of Gender Equality in Education*.)

[111] UNESCO, *World Atlas of Gender Equality in Education*.

Figure 11

Primary completion rates by region and by gender, 1999-2009



Source: UNESCO, *World Atlas of Gender Equality in Education* (Paris, 2012), figure 3.6.1, citing UNESCO Institute for Statistics. Available from http://unesdoc.unesco.org/images/0021/002155/215522e.pdf.

* 2009 data for East Asia and the Pacific refer to 2007.

173. Regarding school-life expectancy,[112] the average number of years of instruction that a child entering the education system can expect to receive also increased between 1990 and 2009, from 8.3 to 11 years for females and from 9.6 to 11.4 years for males. Consistent with progress in primary school completion, the greatest progress in reducing the gender gap in school-life expectancy has been made in South and West Asia, where a girl who started school in 2009 can expect to receive 9.5 years of education, up from 6 years in 1990. Nevertheless, boys continue to have the advantage, with an average school-life expectancy of 10.5 years. Likewise, in sub-Saharan Africa and the Arab States, girls who started school in 2009 can expect to receive 8 and 10 years of education respectively, whereas boys in these regions still have the advantage of at least one extra year of instruction. In East Asia and the Pacific, not only did school-life expectancy for girls rise by 38 per cent between 1990 and 2009, but girls enrolled in primary education can expect to spend about 12 years in school, slightly surpassing the average for males. Similarly, in Latin America and the Caribbean, a girl starting primary school can expect to receive almost 14 years of instruction, compared to 13.3 years for boys.[113]

174. Although gains in secondary education have not been as rapid as those at the primary level, countries around the world are making progress towards increased access to secondary education. Of 187 countries with data, a quarter (27 per cent) have gross enrolment ratios of 98 per cent or more, approaching universal secondary enrolment; however, in 43 per cent of countries, enrolment is less than 80 per cent.[113]

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[112] School-life expectancy is the total number of years of schooling which a child of a certain age can expect to receive in the future, assuming that the probability of his or her being enrolled in school at any particular age is equal to the current enrolment ratio for that age (see UNESCO Institute of Statistics, *Education Indicators, Technical Guidelines*, November 2009).

[113] UNESCO, *World Atlas of Gender Equality in Education*.

175. Access to secondary education remains a challenge for girls in many regions, especially in sub-Saharan Africa and South and West Asia. While the disproportionate exclusion of girls from access to education is not only greater at the secondary than at the primary level, it increases from lower to upper secondary levels. Numerous factors may be the cause, pointing to gender discrimination both inside and outside school, including family and social pressures for girls to devote more time to household work, early marriage, potential increases in emotional and physical dangers as girls age and face risks of sexual harassment and assault, lack of bathrooms, families' unwillingness to pay school fees for girls, and the potentially unsafe daily journey to school for girls and young women.[113]

176. Globally, young males are more likely than young females to enrol in vocational education programmes, though there are notable exceptions such as Burkina Faso and Ethiopia, where females outnumber males.[113]

177. Gains in school enrolment mask other important inequalities, particularly in the quality of education. Access to good quality education is especially limited for those living in poverty. Schools serving poor children characteristically have teachers who are overburdened, unsupervised and underpaid, crowded classrooms and a lack of adequate learning materials, therefore producing poorer outcomes, even in wealthy countries.[114] A recent comparison of the pupil-teacher ratios at primary level in Asian countries, for example, highlights the wide range between countries, from 16 pupils per teacher in Indonesia and Thailand to 17 in China, and up to 40, 41, and 43 pupils per teacher in India, Pakistan and Bangladesh.[115]

178. Quality education includes access to knowledge about human biology and comprehensive sexuality education, which remain underresourced and incomplete in many schools throughout the world, in both poor and wealthy countries.

179. Finally, although access to higher education remains limited in many countries, the last decades have seen a major expansion of higher education in every region of the world, and women have been the prime beneficiaries. Globally, the gross enrolment ratio in tertiary education was 28 per cent for females in 2009, compared with 26 per cent for males. Regionally, more women than men were enrolled in institutions of tertiary education in North America and Western Europe, Central and Eastern Europe, Latin America and the Caribbean, and East Asia and the Pacific, while in sub-Saharan Africa and South and West Asia, the gross enrolment ratios favoured men.[116]

180. Governments' priorities in education for the next 5-10 years highlight their concern for equality in access, the quality of education, and the importance of linking education to decent work opportunities. In addressing these priorities it will be important that teacher shortages be addressed. According to new global projections from the UNESCO Institute for Statistics, the world will need an extra 3.3 million

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[114] See, for example, J. Douglas Willms, *Learning Divides: Ten Policy Questions about the Performance and Equity of Schools and Schooling Systems*, UNESCO Institute for Statistics Working Paper No. 5 (Montreal, 2006).

[115] J. Dreze and A. Sen, *An Uncertain Glory, India and Its Contradictions* (Princeton, New Jersey, Princeton University Press, 2013).

[116] UNESCO, *World Atlas of Gender Equality in Education*.

primary teachers and 5.1 million lower secondary teachers in classrooms by 2030 to provide all children with basic education.[117]

181. **States should commit to and support early and lifelong learning, including pre-primary education, to ensure that every child, regardless of circumstance, completes primary education and is able to read, write and count, to undertake creative problem-solving and to responsibly exercise his or her freedoms. States should also ensure access to secondary education for all and expand post-secondary opportunities; enable the acquisition of new skills and knowledge at all ages; and enhance vocational education and training, and work-directed learning linked to the new and emerging economies.**

Human rights elaborations since the International Conference on Population and Development

Box 7

Education

Binding instruments. The regional human rights systems contain specific protections of the rights of young people to education. The Council of Europe European Revised Social Charter (1996; entry into force 1999) reaffirms the right of young persons to "a free primary and secondary education as well as to encourage regular attendance at schools". The Ibero-American Convention on the Rights of Youth (2005; entry into force 2008) recognizes that "youth have a right to education" and stipulates that "States Parties recognize their obligation to guarantee a comprehensive, continuous, appropriate education of high quality". The African Youth Charter (2006, entry into force 2009), states that "[e]very young person shall have the right to education of good quality" and embraces "the value of multiple forms of education, including formal, non-formal, informal, distance learning, and lifelong learning, to meet the diverse needs of young people".

Other soft law. General comment No. 13 on the right to education, adopted by the Committee on Economic, Social and Cultural Rights (1999), recognizes that "[e]ducation is both a human right in itself and an indispensable means of realizing other human rights. As an empowerment right, education is the primary vehicle by which economically and socially marginalized adults and children can lift themselves out of poverty and obtain the means to participate fully in their communities. Education has a vital role in empowering women, safeguarding children from exploitative and hazardous labour and sexual exploitation, promoting human rights and democracy, protecting the environment, and controlling population growth … [A] well-educated, enlightened and active mind, able to wander freely and widely, is one of the joys and rewards of human existence".

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[117] UNESCO Institute for Statistics, "A teacher for every child; projecting global teacher needs from 2015 to 2030", UIS Factsheet No. 27 (October 2013).

5. Government priorities: Education

Improve quality standards in education, including the curriculum	61 per cent of Governments
Maximize social inclusion, equal access and rights to education	54 per cent of Governments
Capacity strengthening (human resources in education)	43 per cent of Governments
Development of education programmes, policies, strategies, laws/creation of institutions	43 per cent of Governments
Capacity strengthening (build, expand and equip schools)	36 per cent of Governments

182. When asked to identify public policy priorities for education over the next 5-10 years, over half of Governments highlighted the importance of "improving quality standards in education, including the curriculum" (61 per cent) and "maximizing social inclusion, equal access and rights" (54 per cent). The need to improve the quality and coverage of education were in fact the top two priorities identified by Governments in all regions, although Africa was the only region where a higher proportion of Governments mentioned coverage (61 per cent) than quality (55 per cent), pointing to the unfinished agenda of universal enrolment.

183. Two other priorities linked to labour and infrastructure investments in the educational system garnered the next tier of support and were mentioned by over a third of Governments: "capacity strengthening (human resources in education)" (43 per cent) and "capacity strengthening (build, expand and equip schools)" (35 per cent). A regional breakdown shows that the proportion of countries in Africa that identify both priorities is higher than the world average (human resources: 55 per cent; infrastructure: 45 per cent), while in Europe it is lower (human resources: 31 per cent; infrastructure: 23 per cent).

184. While one third of countries globally cite "training to work/education-employment linkages" (33 per cent) as their priority, this issue is of special relevance for a higher proportion of countries in Europe (58 per cent) and Oceania (46 per cent), illustrating the need for transforming education to better suit the job market.

185. Facilitating access to and improving the quality of "pre-school education" is a priority for one in every four countries in the Americas (25 per cent), demonstrating that early childhood development is key to foster the capabilities of children in their first years of life. In all other regions, no more than 15 per cent of Governments identified it as a priority.

186. Finally, "gender parity", which captures all priorities pertaining to ensuring equality in school enrolment and completion rates between males and females, was identified as a priority by about one fifth of Governments in Asia (20 per cent) and Africa (18 per cent), while this issue was of lesser concern for Governments in the Americas (9 per cent), Oceania (8 per cent) and Europe (4 per cent).

6. Youth employment

187. Achieving decent work for young people is crucial for the progression towards wealthier economies, fairer societies and stronger democracies. Decent work involves opportunities for work that are productive and deliver a fair income; provides security in the workplace and social protection for workers and their families; offers better prospects for personal development; and empowers people by giving them the freedom to express their concerns, to organize and to participate in decisions that affect their lives.[118]

188. The challenge of providing decent work to young people is a concern for both industrialized and developing countries. Of the estimated 197 million unemployed people in 2012, nearly 40 per cent were between 15 and 24 years of age.[119] The economy will need to create 600 million productive jobs over the next decade in order to absorb the current unemployment levels and to provide employment opportunities to the 40 million labour market entrants each year over the next decade.[120]

189. Figure 12 illustrates the overall decline in youth employment-to-population ratios, highlighting that job opportunities have not kept pace with the growing youth population, nor has increased school enrolments. Youth (age 15-24 years) employment-to-population ratios have declined for both males and females in all regions of the world since 2000. Male youth employment remains higher (49 per cent) than females' (35 per cent), reflecting the movement of many young women into early marriage and childbearing by this age, and thereby into unpaid work within the household.

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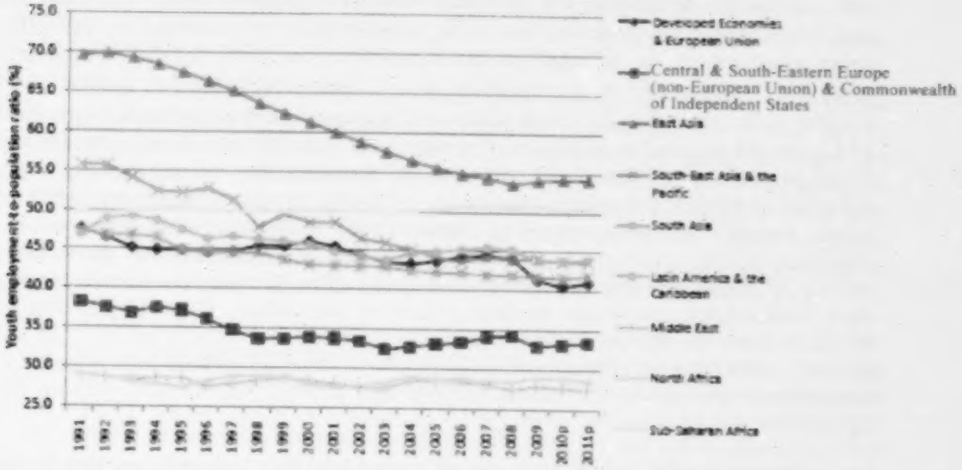
[118] ILO, "Promoting youth transitions to decent work: empowering young people through employment", paper prepared for the Global Youth Forum, Bali, Indonesia, 4-6 December 2012.

[119] ILO, *Global Employment Trends for Youth 2013: A Generation at Risk* (Geneva, International Labour Office, 2013).

[120] ILO, *Global Employment Trends 2012: Preventing a Deeper Jobs Crisis* (Geneva, International Labour Office, 2012).

Figure 12

Youth employment-to-population ratio by region, 1991-2011



p = projection

Source: International Labour Organization (ILO). *Global Employment Trends for Youth* (Geneva. 2010). figure 4.

190. Although all regions face a youth employment crisis, large differences exist across countries and regions. For example, youth unemployment rates in 2012 were highest in the Middle East and North Africa, at 28 per cent and 24 per cent, respectively, and lowest in East Asia (10 per cent) and South Asia (9 per cent). The youth unemployment rate for the developed economies and the European Union in 2012 was estimated at 18 per cent, the highest level for this group of countries in the past two decades.[119]

191. Gender differentials in youth unemployment rates are small at the global level and in most regions. Regional youth unemployment rates are lower for young women in the advanced economies and East Asia. However, large gaps between female and male rates are evident in some regions, such as North Africa and the Middle East, and, to a lesser extent, Latin America and the Caribbean, with young women at a disadvantage. Household wealth, investment in education and urban origin offer critical advantages to youth undertaking the transition from education to the labour market, and in countries where such data are available, young males are more likely than young females to complete the transition to stable and/or satisfactory employment.[119]

192. In many countries, the unemployment scenario is further aggravated by the large numbers of young people in poor quality and low paid employment with intermittent and insecure work arrangements, including in the informal economy. As many as 60 per cent of young persons in developing regions are either without work, not studying, or engaged in irregular employment and thus not achieving their full economic potential.[119] According to ILO, youth account for 24 per cent of the total working poor, compared with 19 per cent of non-poor workers in the 52 countries where data are available.[118] Many of the young working poor are in countries and regions where unemployment rates are relatively low, such as South Asia, East Asia and sub-Saharan Africa.[119] Furthermore, where age-disaggregated data on

informality are available, they confirm that young workers are more likely to work in the informal sector than their adult counterparts.[119]

193. A review of the policy frameworks of several countries shows that since the mid-2000s, there has been an increasing commitment by countries to prioritize youth employment in national policy frameworks, as reflected in the poverty reduction strategies of low-income countries.[121] Compared to the first generation of poverty reduction strategies, from which youth employment was absent, nearly half of the second-generation strategies prioritize youth employment. Similar results are found in national development strategies of countries that do not have poverty reduction strategies. Increased attention to youth employment is necessary to ensure young people's effective transition from school to decent jobs; however, the challenge of job creation is particularly daunting for countries that have large cohorts of youth entering their productive years. The 49 poorest countries face a stark demographic challenge, as their collective population, about 60 per cent of which is under the age of 25, is projected to double to 1.7 billion by 2050. In the coming decade these countries will have to create about 95 million jobs in order to absorb new entrants to the labour market, and another 160 million jobs in the 2020s.[122]

194. **States should invest in building young people's capabilities and equip them with the skills to meet the labour demands of the current and emerging economies, and develop labour protection policies and programmes that ensure employment that is safe, secure and non-discriminatory and that provides a decent wage and opportunities for career development. Efforts must also include a focus on productive investment in technologies, machineries, infrastructure, and the sustainable use of natural resources to create employment opportunities for young people.**

7. Government priorities: adolescents and youth

Economic empowerment and employment	70 per cent of Governments
Maximize social inclusion, equal access and right	46 per cent of Governments
Education	46 per cent of Governments
Sexual and reproductive health information and services for youth, including HIV	38 per cent of Governments
Training to work	36 per cent of Governments

195. Governments that responded to the global survey regarding their priorities for adolescents and youth in the coming 5-10 years expressed strong support for their economic empowerment, preparing them for full participation in the labour market, and the importance of their social protection and rights. "Economic empowerment and employment" was especially noted by Governments of poorer countries: 69 of 85 Governments in the bottom two World Bank income categories, versus 16 of 33 Governments in the top two income categories. Youth cohorts are

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[121] For a review of policies and programmes for youth employment see ILO, *The Youth Employment Crisis: Time for Action* (Geneva, International Labour Office, 2012).

[122] *The Least Developed Countries Report 2013: Growth with Employment for Inclusive and Sustainable Development* (United Nations publication, Sales No. E.13.II.D.1).

larger in countries lower on the income ladder owing to higher fertility in recent years, and providing employment, particularly employment that leads out of poverty, is very challenging. Youth unemployment has become an enormous issue in wealthier countries also, particularly since the 2008 global economic crisis, underscoring the priority Governments assign to this issue.

196. That "maximizing social inclusion, equal access and rights" is a global priority was reflected in the fact that it was mentioned by a majority of countries in Europe (63 per cent of Governments) and the Americas (56 per cent); in Africa and Asia, approximately 40 per cent of Governments highlighted it. The Programme of Action recognized the critical role of youth and the need to integrate them into society. Priority areas under "social inclusion, equal access and rights" included addressing neglect, discrimination and ensuring human rights protections, areas of significant focus in the declaration adopted at the Global Youth Forum in Bali.

197. Three additional priorities were very common among Governments. The first, "sexual and reproductive health information and services for youth, including HIV", was listed as a priority by 38 per cent of Governments globally but was a high priority for half of all countries in Africa and Asia, half of low-income and lower-middle-income Governments and 40 per cent of all upper-middle-income Governments. However, only 1 of the 33 wealthiest countries included sexual and reproductive health among their top five priorities for youth, which may reflect the better access to health existing in most of the wealthiest countries.

198. "Political empowerment and participation" was highlighted by 38 per cent of Governments, evenly distributed regionally and by income. This provides a strong complement to, and a mechanism for achieving, both social inclusion and rights and economic empowerment, and highlights the rising strength of youth in influencing social, economic and political systems. Finally, "training to work" was listed by 36 per cent of Governments globally, including 52 per cent of African Governments and 56 per cent of low-income Governments.

199. Taken together, this collection of priorities — economic empowerment; education, both generally and targeted for work; sexual and reproductive health; and political empowerment — reinforce Governments' emphasis on strengthening the capabilities of their young people.

D. Older persons

1. The demographic importance of population ageing

200. An inevitable consequence of demographic changes resulting from fertility decline and increased longevity is population ageing. One of humanity's greatest achievements is that people are living longer and healthier lives, with the number and proportion of older persons aged 60 years or over rising in all countries. Population ageing presents social, economic and cultural challenges to individuals, families and societies, but also opportunities to enrich entire households and the larger society. From 1990 to 2010, the population aged 60 years or over increased in all regions, with Asia adding the greatest number of older persons, 171 million, to its population. From 2005 to 2010, the annual growth rate of the population aged

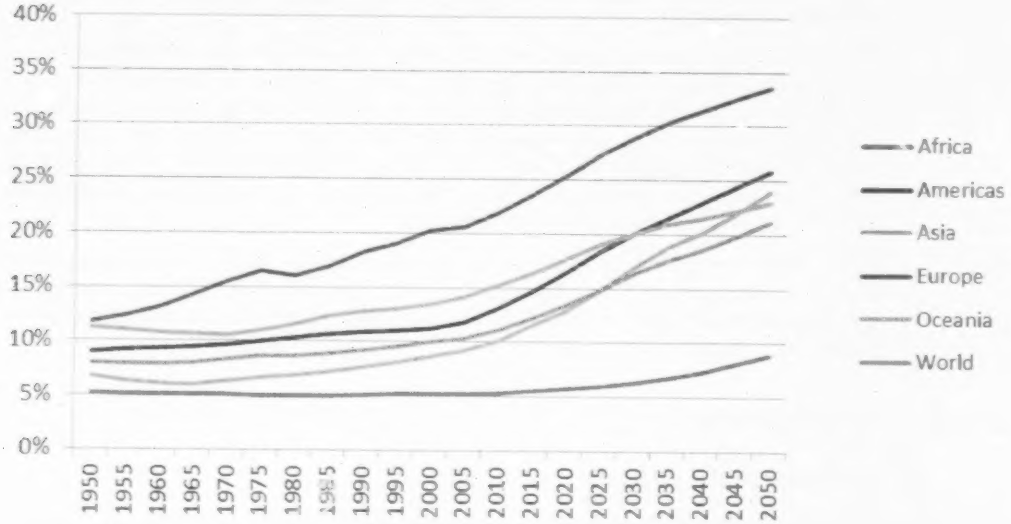
60 years or over was 3 per cent, while that of the total population was 1 per cent. In the coming decades, this gap is expected to widen.[123]

201. Globally, in the past 20 years, the population of older persons aged 60 years or over has increased by 56 per cent, from 490 million in 1990 to 765 million in 2010. During this period, the increase in the population of older persons in developing countries (72 per cent) was more than twice that of developed countries (33 per cent). The number and proportion of older persons are rising in almost all countries, with projections estimating that more than 20 per cent of the global population will be aged 60 and above by 2050 (see figure 13). Persons aged 60 and above already make up more than 20 per cent of the population in Europe and 15 per cent of the population in Oceania, and are anticipated to make up 15 per cent of the population in the Americas by 2015. If projections of rapid growth in the population of older persons in the coming decades are correct, the number of older persons will surpass the number of children by 2047. Many developed countries are already facing extremely low old-age support ratios.[123]

Figure 13

Trends and projections in the proportion of older persons (over 60 years), worldwide and by region, 1950-2050

(Medium fertility variant)



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[123] *World Population Prospects: The 2012 Revision* (see footnote 7 above).

Figure 13.a

Trends and projections in the proportion of older persons (over 60 years) in Africa, by subregion, 1950-2050

(Medium fertility variant)

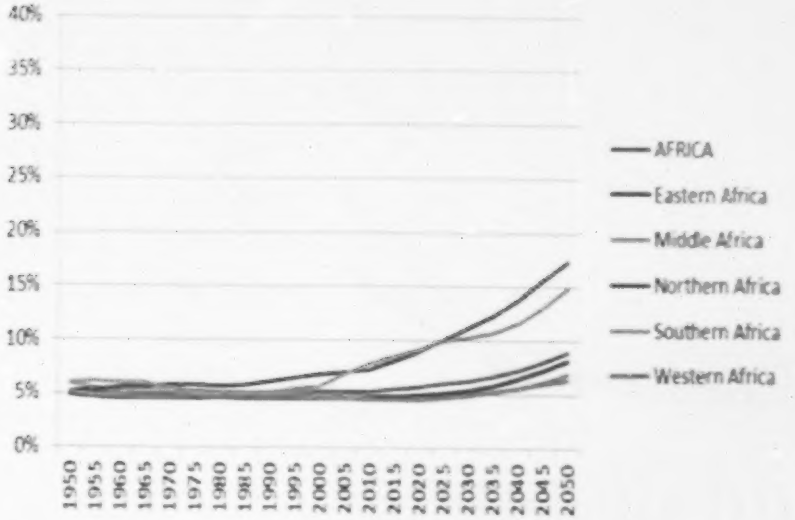


Figure 13.b

Trends and projections in the proportion of older persons (over 60 years) in the Americas, by subregion, 1950-2050

(Medium fertility variant)

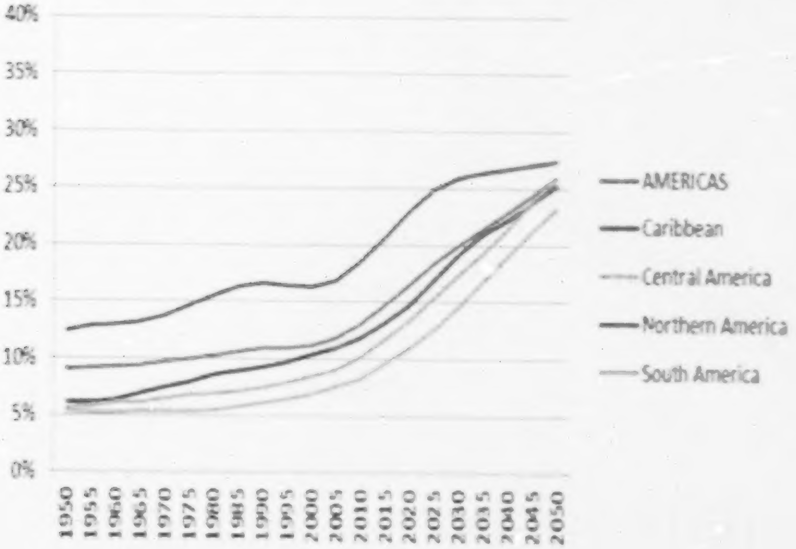


Figure 13.c

Trends and projections in the proportion of older persons (over 60 years) in Asia, by subregion, 1950-2050

(Medium fertility variant)

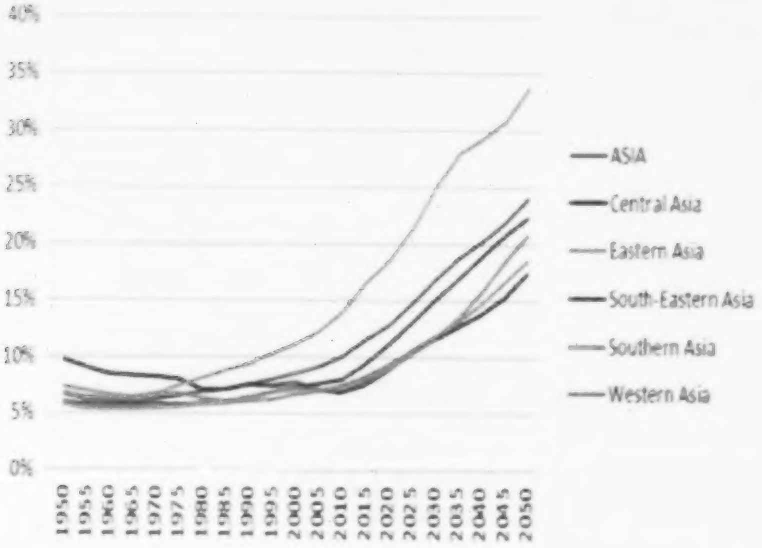


Figure 13.d

Trends and projections in the proportion of older persons (over 60 years) in Europe, by subregion, 1950-2050

(Medium fertility variant)

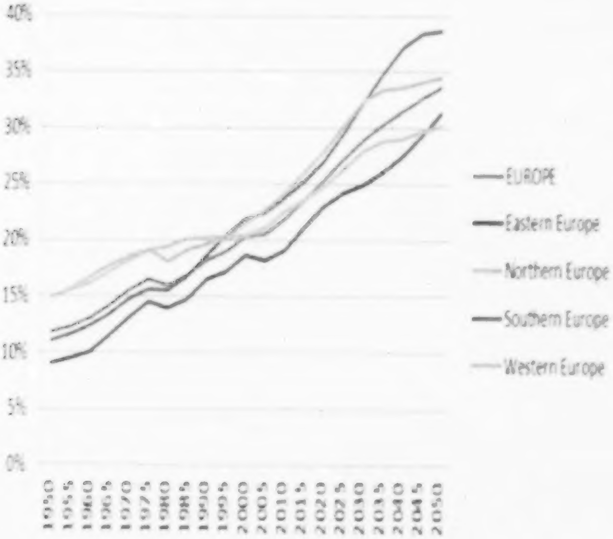
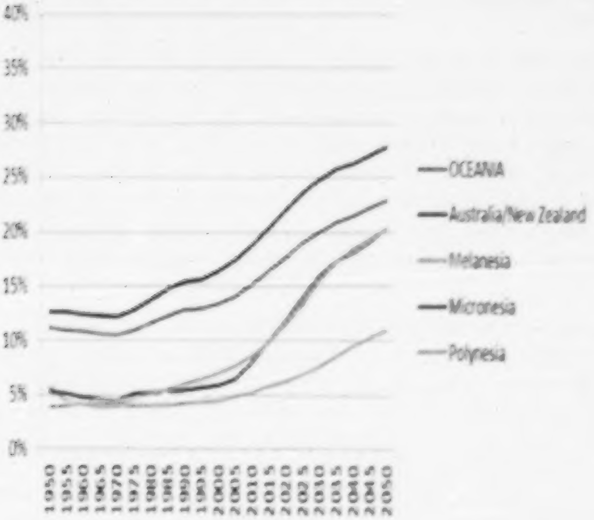


Figure 13.e
Trends and projections in the proportion of older persons (over 60 years) in Oceania, by subregion, 1950-2050



Source: *World Population Prospects: The 2012 Revision*, November 2013 (ST/ESA/SER.A/336).

202. Subregional trends highlight the low proportion of persons aged over 60 years in Africa, but greater proportions in Southern and Northern Africa relative to other subregions. All subregions of the Americas are ageing rapidly, with North America furthest ahead. Within Europe, in 2010 only Eastern Europe had a population of persons aged over 60 years of less than 20 per cent, but it will pass that mark soon. In Asia, only Eastern Asia had an over-60 population of more than 10 per cent, but all subregions are ageing quickly. Oceania remains diverse, with Australia and New Zealand closer to European proportions.

203. Owing to longer life expectancy among women than among men at older ages, elderly women outnumber elderly men in most societies. In 2012, globally there were 84 men per 100 women in the age group 60 years or over and 61 men per 100 women in the age group 80 years or over.[123] Integrating gender into policies and support for older persons is therefore critical, including in health, other types of care, family supports and employment.

204. Older individuals are much more likely to live independently in developed countries than in developing countries. Globally, 40 per cent of older persons aged 60 years or over live alone or only with their spouse, and older persons living alone are more likely to be women given their longer life expectancy. But the living arrangements of older people vary greatly by level of development. About three quarters of older persons in developed countries live independently, compared with only one quarter in developing countries and only one eighth in the least developed countries.[124] Population ageing demands attention to the physical infrastructure to

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[124] United Nations, "Population ageing and development: ten years after Madrid", *Population Facts* No. 2012/4, December 2012; *Population Ageing and Development 2012* (wall chart) (United Nations publication, Sales No. E.12.XIII.6).

ensure safe housing, mobility and the means of meaningful participation of older persons. **States should modify legislation, design and planning guidelines, and infrastructure to ensure that the increasing number of older, single persons have access to needed and appropriate housing, transport, recreation and the amenities of communal life.**

205. The sexual health of older persons is often overlooked both in academic discourse and policy responses to rapid population ageing, perhaps because the subject of sexuality in older people remains largely taboo in many cultures. Yet in a recent large study of older adults in the United States of America, in which a broad definition of sexual functioning was used, women between 57 and 74 years showed no decline in sexual activity.[125] Sexual functioning was found to be more associated with self-rated physical health than age. **States should adapt policies and programmes on sexual health to better meet the changing sexual needs of older persons.**

206. As people live longer, there are growing concerns about the sustainability of benefits such as pensions, health care and old-age support, which will need to be paid over longer periods. There are also concerns about the long-term viability of intergenerational social support systems, which are crucial for the well-being of both the older and younger generations. Such concerns are especially acute in societies where provision of care within the family becomes increasingly difficult as family size decreases and as women, typically the main caregivers, work outside the home. Increasing longevity may also result in rising medical costs and increasing demands for health services, since older people are typically more vulnerable to chronic diseases.[126]

207. **States should ensure the social protection and income security of older persons, with particular consideration for older women, those living in isolation and those providing unpaid care, by extending pension systems and non-contributory allowances and by strengthening intergenerational solidarity, and by ensuring the inclusion and equitable participation of older persons in the design and implementation of policies, programmes and plans that affect their lives.**

208. At the same time, many persons continue to contribute to their families, communities and societies well into old age. Not all older persons require support, nor do all persons of working age provide direct or indirect support to older persons. In fact, older persons in many societies are often providers of support to their adult children and grandchildren.[127] Further, while expenditures in health care and other sectors that cater to older populations may be a challenge, they are also an investment. The expansion of these sectors generates important employment

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[125] M. Lusti-Narasimhan and J. R. Beard, "Sexual health in older women", *Bulletin of the World Health Organization*, vol. 91, No. 9 (2013), pp. 707-709.

[126] *Current Status of the Social Situation, Well-Being, Participation in Development and Rights of Older Persons Worldwide* (ST/ESA/339); United Nations, "Population ageing and development: ten years after Madrid"; United Nations, "Population ageing and the non-communicable diseases", *Population Facts*, No. 2012/1, April 2012.

[127] R. Lee and A. Mason, *Population Ageing and the Global Economy: A Global Perspective* (Cheltenham, United Kingdom, Edward Elgar, 2011); United Nations, "Population ageing and development: ten years after Madrid"; *Current Status of the Social Situation, Well-Being, Participation in Development and Rights of Older Persons Worldwide*.

opportunities in both the public and private health-care sectors.[128] **States should strengthen health and care systems by promoting universal access to an integrated, balanced continuum of care through old age, including chronic disease management, end-of-life and palliative care.**

209. In 2002, the international community gathered in Madrid for the Second World Assembly on Ageing to discuss the growing challenges of population ageing. By then, it was clear that ageing was no longer a concern of developed countries alone; it was affecting, or beginning to affect, an increasing number of countries, both developed and developing, and its social, economic and political consequences could no longer be ignored. The phenomenon of population ageing could no longer be considered a stand-alone issue or an afterthought. The Second World Assembly and its outcome document, the Madrid International Plan of Action on Ageing, 2002 (see A/CONF.197/9, chap. I) marked the first time that Governments agreed to link questions of ageing to other frameworks for social and economic development and to human rights agreed at previous United Nations conferences and summits.

2. Lifelong education, economic and social participation

210. The Programme of Action recommended that Governments enhance and promote older persons' self-reliance, quality of life and ability to work as long as possible and desired, and enable their continued participation using their skills and abilities fully for the benefit of society. Many older persons continue to work and often their earnings support the entire household. Older persons may also wish to lead satisfying professional lives. Flexible employment, lifelong learning and retraining opportunities are critical to enable and encourage older persons to remain in the labour market, for their own benefit, for that of their families, and as an essential resource for successful economies that cannot afford to lose their experience and expertise.

211. In the years following the International Conference on Population and Development, the Hamburg Declaration on Adult Learning, adopted at the Fifth International Conference on Adult Education (1997), and the Madrid International Plan of Action on Ageing, 2002 affirmed the importance of education for older persons.[129] The provision of lifelong education enables persons of all ages to strengthen and augment their literacy and related skills, to adapt to changing employment opportunities and to participate fully in changing personal and economic conditions, to the benefit of themselves, their families, their communities and the society at large. Lifelong learning is not only for older persons; it is also for young or middle-age workers experiencing loss or change of employment, or who may have missed earlier opportunities to get an education because of poverty, early entry into employment, early childbearing, or voluntary or forced mobility. In addition, a global network of universities of the third age focus on education to

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[128] F. Colombo and others, *Help Wanted? Providing and Paying for Long-Term Care*, OECD Health Policy Studies (Paris, OECD Publishing, 2011), p. 336; Organization for Economic Cooperation and Development (OECD), Health at a Glance 2013: OECD Indicators (Paris, OECD Publishing, 2012).

[129] See UNESCO, *Fifth International Conference on Adult Education: Final Report*, Hamburg, Germany, 14-18 July 1997; available from www.unesco.org/education/uie/confintea/pdf/finrepeng.pdf (accessed 7 October 2013); Du Peng, "The third age: opportunity for learning and teaching", *Population Ageing and the Millennium Development Goals* (New York, United Nations Population Fund, 2009), p. 157; United Nations, The Madrid International Plan of Action on Ageing: Guiding Framework and Toolkit for Practitioners and Policy Makers (March 2008); available from www.un.org/ageing/documents/building_natl_capacity/guiding.pdf (accessed 27 September 2013).

enhance quality of life for retired persons. Their membership has expanded further in response to the growing demands of non-retired persons for non-formal education.[130]

212. Ninety-two per cent of Governments appear to have some policy on adult education, which overwhelmingly targets skills development and training for the labour market, an oft-cited priority of ministers of education in both developing and developed countries.[131] Since 2000, numerous countries or territories, including Belize, Canada, China, Denmark, El Salvador, Hungary, Japan, Mexico, Puerto Rico the Russian Federation, Serbia and Sweden, have adopted policies and initiatives focusing on retraining older persons.[132]

213. Despite national policies on lifelong education and retraining, adult illiteracy remains high, and 651 million adults aged 25 and over are functionally illiterate (2011 data), the majority (64 per cent) of them women.[133] Among persons aged 65 or older, the total global illiteracy rate is 26 per cent, ranging from 25 per cent in Latin America to 68 per cent in Africa, with rates among women consistently above those of men. Adult illiteracy rates are higher in rural areas and in zones of conflict, and among persons with disabilities and ethnic minority populations.[134]

214. Illiteracy traps many in a cycle of poverty, with limited opportunities for employment or income generation, and a greater likelihood of poor health.[135] The effects of illiteracy, incomplete and/or poor quality education (see sect. II.C.4 above on uneven progress in education) linger throughout the life course, with adverse consequences in particular for adults and older persons in countries without social security systems, who may be compelled to work at older ages in informal, physically demanding and poorly paid work.[136]

215. In 2002, 88 per cent of Governments reported having a law or policy on adult literacy.[137] In Cambodia, where 70 per cent of women over 65 years old cannot read or write, adult literacy classes organized with volunteer teachers (retired schoolteachers and monks) markedly improved older women's ability to read and

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[130] In China, there are 32,697 universities of the third age, serving 3,335,093 students; in the United Kingdom there are 903, with 319,185 students (see Du Peng, "The third age", p. 159); University of the Third Age, United Kingdom (http://www.u3a.org.uk/u3a-movement.html).

[131] See UNESCO, *Second Global Report on Adult Learning and Education: Rethinking Literacy* (Hamburg, Germany, UNESCO Institute for Lifelong Learning, 2013), table 2.2.

[132] UNFPA and HelpAge International, *Ageing in the Twenty-First Century: A Celebration and A Challenge* (New York and London, 2012), p. 190.

[133] See UNESCO, *Second Global Report on Adult Learning and Education: Rethinking Literacy* (Hamburg, Germany, UNESCO Institute for Lifelong Learning, 2013).

[134] Ibid., p. 19; see also N. E. Groce and P. Bakshi, "Illiteracy among adults with disabilities in the developing world: an unexplored area of concern", Working Paper Series No. 09 (University College London, Leonard Cheshire Centre for Disability and Inclusive Development, August 2009).

[135] See World Bank, "Defining welfare measures" (http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTPOVERTY/EXTPA/0,,contentMDK:20242876~isCURL:Y~menuPK:492130~pagePK:148956~piPK:216618~theSitePK:430367~isCURL:Y,00.html; accessed 27 September 2013); A. Cree, A. Kay and J. Steward, "The economic and social cost of illiteracy: a snapshot of illiteracy in a global context" (World Literacy Foundation, April 2012), p. 2, available from www.worldliteracyfoundation.org/The_Economic_&_Social_Cost_of_Illiteracy.pdf (accessed 29 September 2013).

[136] UNFPA and HelpAge International, *Ageing in the Twenty-First Century: A Celebration and A Challenge*, p. 55.

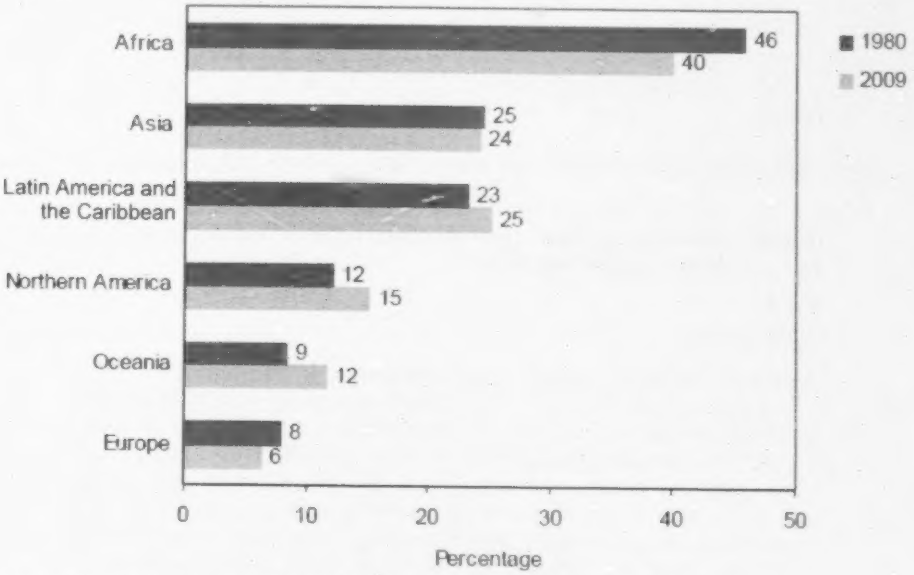
[137] See UNESCO, *Second Global Report on Adult Learning and Education: Rethinking Literacy*, table 2.3.

perform calculations, enabling them to set up small stores and businesses.[138] **States should strengthen lifelong learning and adult literacy opportunities that enable all persons, regardless of age, to gain new skills for a changing economy, pursue better employment and income, or simply explore the development of personal talents and ambitions.**

216. Globally, the highest proportion of older persons participating in the labour force is in Africa, where more than 40 per cent of those over 65 years of age are economically active, followed by Asia, Latin America and the Caribbean, with nearly 25 per cent (see figure 14).

Figure 14

Labour force participation of older persons as a proportion of total population aged 65 and over by region, 1980-2009



Source: United Nations, World Population Ageing 2009 (ESA/P/WP/212), figure 38.

217. Given their longer life expectancy, women make up an increasing proportion of the older workforce, and the likelihood of their participating in the labour force after age 65 has been rising for several decades (see figure 15) even as the likelihood of men's working after age 65 has declined. Women's increased participation in the older workforce and greater rates of illiteracy contribute to the persistent inequalities faced by working women and the greater likelihood of their participating in informal, insecure and lower-paid work (see sect. II.B.1 above on changing patterns in productive and reproductive roles. **States should monitor and eradicate all forms of discrimination in employment against older persons; and develop labour protection policies and programmes that ensure employment that is safe, secure, and that provides a decent wage.**

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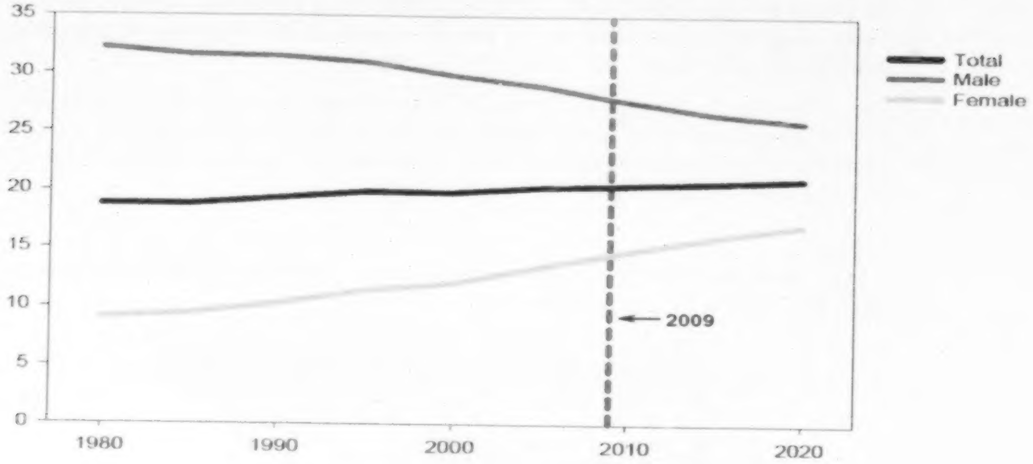
[138] J. Pugh, "Changing lives through literacy", cited in *Ageing in the Twenty-First Century: A Celebration and A Challenge*, p. 59.

Figure 15

Global labour force participation age 65 and over by sex, 1980-2020



Source: United Nations, World Population Ageing 2009 (ESA/P/WP/212), figure 36.

Human rights elaborations since the International Conference on Population and Development

Box 8

Older persons

Intergovernmental human rights outcomes. In resolution 65/182 on follow-up to the Second World Assembly on Ageing (2011), the General Assembly decided to establish an open-ended working group on ageing in order to strengthen recognition of the human rights of older persons, assess gaps, and consider, as appropriate, the feasibility of implementing further instruments and measures. In resolution 67/139, entitled "Towards a comprehensive and integral international legal instrument to promote and protect the rights and dignity of older persons" (2013), the Assembly decided that the Open-ended Working Group on Ageing would "consider proposals for an international legal instrument to promote and protect the rights and dignity of older persons".

Other intergovernmental outcomes. The Madrid Political Declaration and International Plan of Action on Ageing, 2002, adopted at the Second World Assembly on Ageing, offered a new agenda on ageing in the twenty-first century focusing on: older persons and development; health and well-being into old age; and ensuring enabling and supportive environments.

Other soft law. Regional systems have also shown increased momentum towards developing mechanisms to promote, protect and fulfil the human rights of older persons. The African Commission on Human and Peoples' Rights, the Inter-American system and the Steering Committee for Human Rights of the Council of Europe have all established working groups with the aim of drafting an instrument to promote the human rights of older persons.

218. The results of the global survey show that a higher percentage of countries with old-age structures address the issues related to the needs of older persons. These are countries with current old-age dependency ratios higher than 12 persons aged 65 or over per 100 persons of working age (15-64).

219. Globally, 40 countries whose populations will be ageing rapidly over the next two decades — including Brazil, China, India, Indonesia, the Islamic Republic of Iran, Mexico and Viet Nam — have an old-age dependency ratio between 6 and 12 in 2010; it is estimated that the ratio will increase to more than 12 in 2030 (medium projection). A high proportion of these countries addressed the issues of "providing social services including long-term care" (94 per cent), "providing affordable, appropriate and accessible health care" (91 per cent), "extending or improving old age allowances" (88 per cent), "enabling older persons to live independently as long as possible" (89 per cent) and "collecting disaggregated data" (88 per cent).

220. Such progress in the areas of social protection, health care and data collection have not been matched by advances in employment, non-discrimination or participation in society: a smaller share of countries mentioned "addressing neglect, abuse and violence against older persons" (74 per cent), "enabling older persons to make full use of their skills and abilities" (69 per cent), "providing support to families caring for older persons" (67 per cent), "instituting concrete procedures and mechanisms for participation" (63 per cent), "preventing discrimination against older persons, especially widows" (58 per cent) and "promoting employment opportunities for older workers" (39 per cent). **States should monitor and eradicate all forms of direct and indirect abuse, including all forms of violence, overmedication, substandard care and social isolation.**

3. Government priorities: older persons

Preventive and curative health care	54 per cent of Governments
Economic empowerment, employment and pensions/support schemes	54 per cent of Governments
Development of programmes, policies and strategies and the creation of laws and institutions related to older persons	39 per cent of Governments
Social inclusion and rights of older persons	37 per cent of Governments
Elder care	36 per cent of Governments

221. When countries were asked to identify the most relevant issues anticipated to receive priority in public policy related to older persons, "preventative and curative

health care" was a particular focus of countries in Africa, where 68 per cent listed it among their top five priorities; in Europe, Asia and the Americas, about half of countries included it, as did 3 of 10 countries in Oceania. European and Asian countries listed "economic empowerment, employment and pensions" most often (62 per cent and 59 per cent respectively). In these two regions, as well as in the Americas, the identification of economic contributions and sustainable support systems for older persons aligns with the significant progression of ageing and the need to maintain both economic growth and social welfare given the relative decline in traditional working age populations.

222. Despite high poverty rates among older persons around the world and across country income groupings, "addressing poverty" among older persons emerged as a priority only among African countries, of which nine listed it. Only three countries in the other regions combined reported it to be a priority.

223. In line with the significant shift reflected in the Madrid International Plan of Action on Ageing, "social inclusion and rights" of older persons was a consistent priority of about 40 per cent of countries in Africa, the Americas and Europe. Only 9 of 41 Asian countries listed it, however, and only 1 country in Oceania. Prioritization of "social inclusion and rights" was also more frequently found on the higher end of the income spectrum: over 40 per cent of upper-middle, high non-OECD and OECD countries and 30 per cent of low- and lower-middle-income countries listed it as a priority.

224. "Capacity strengthening" on ageing, particularly in the areas of data and research, emerged more frequently as a priority among low-income countries, 10 of 32 of which included it among their top five priorities. Low-income countries are in the early stages of a transition to an ageing population, but they share other countries' awareness of the need for support for older persons and some are clearly looking to expand the evidentiary basis for government actions.

E. Persons with disabilities

225. Disability is experienced by the majority of people in the world at some point in their lives, some throughout their lives, some moving in and out of disability. It is variously estimated that 15 to 20 per cent[139] of persons 15 years and older around the world currently live with a disability, 2-4 per cent of whom have a significant or severe disability. According to the WHO *World Report on Disability*, approximately 93 million, or 5 per cent, of children aged 0-14 are disabled.[140]

226. Disability is experienced unevenly across countries: those with per capita GDP below US$ 3,255 have a total disability prevalence of 18 per cent, compared with just 12 per cent for those above this figure. Women are also significantly more prone to disability than men: 22 per cent of women in lower-income countries and 14 per cent in higher-income countries have a disability.[140]

227. The likelihood of having a disability rises dramatically with age, with over 46 per cent of all people over 60 years of age having a moderate or severe disability

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[139] Lower estimate based on *World Health Survey*, cited in WHO and World Bank, *World Report on Disability* (Geneva, World Health Organization, 2011); higher estimate based on *The Global Burden of Disease: 2004 Update* (Geneva, World Health Organization, 2008), cited in *World Report on Disability*.

[140] WHO and World Bank, *World Report on Disability*.

compared with just 15 per cent of people aged 15-49 years. The number of persons with disabilities is growing, as a result of both general population ageing and the spread of non-communicable diseases associated with disability, such as diabetes, heart disease and mental illness.[140]

228. There is a suggestive, though understudied, link between poverty and disability, both as a driver and as a consequence of disability.[141] Causality between disability and poverty is not well established owing to limited availability of longitudinal data and the fact that poverty is frequently measured at the household level. Studies in both developed and developing countries have shown that disability hampers educational attainment and interferes with labour market participation.[142] **States should monitor and eradicate all forms of discrimination in employment against persons with disabilities and develop enabling policies and programmes that ensure employment that is safe and secure, and provides a decent wage.**

229. Persons experiencing a disability are more likely to experience "violations of dignity",[142] including social exclusion, violence and prejudice, than persons without a disability. And the implications of disability, including the need for social support, extend beyond the individual to households and families impacted by disability, given the added cost of resources spent on health care, loss of income, stigma, and the need for support systems for caregivers. **States should monitor and eradicate all forms of direct and indirect discrimination against persons with disabilities, including all forms of interpersonal violence, overmedication and substandard care, and the social isolation of such persons, through national programmes, particularly in the areas of education, employment, rehabilitation, housing, transportation, recreation and communal life, as well as support for family caregivers.**

230. The World Programme of Action concerning Disabled Persons (1982), the Programme of Action of the International Conference on Population and Development (1994), the Convention on the Rights of Persons with Disabilities (2006) and the outcome document of the high-level meeting of the General Assembly on the realization of the Millennium Development Goals and other internationally agreed development goals for persons with disabilities: the way forward, a disability-inclusive development agenda towards 2015 and beyond (General Assembly resolution 68/3 of 23 September 2013) all recognized that persons with disabilities constitute a significant portion of global and national populations. These documents set as objectives the realization of human rights, participation, equal opportunities, valuing of capabilities in social and economic development, and dignity and self-reliance for persons with disabilities. **States should take concrete measures to realize their commitments to enhancing accessibility and inclusive development and to enabling full participation in social, economic and political life for all, including persons with disabilities.**

231. National and global data on disability also suffer from significant validity and comparability problems, leading to highly variable estimates, as well as frequent undercounting, owing in part to stigma associated with the term. The Washington Group on Disability Statistics, which promotes international cooperation in health statistics by focusing on disability measures suitable for censuses and national

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[141] J. Braithwaite and D. Mont, "Disability and poverty: a survey of World Bank poverty assessments and implications", *European Journal of Disability Research*, vol. 3, No. 3 (2009), pp. 219-232.

[142] WHO and World Bank, *World Report on Disability*.

surveys, is making continuous progress in the measurement of disability. Strengthening definitions and data systems for monitoring and addressing disability is critical for defining and monitoring progress towards well-being and participation. Enhanced international cooperation to this end is more vital than ever before.

232. According to the responses to the global survey, the primary issue of concern relevant to persons with disabilities that is being addressed by countries is "ensuring a general education system where children are not excluded on the basis of disability". It is worth noting that 82 per cent of countries, that is, all except 28 (13 in Africa, 6 in Asia, 6 in the Americas, 2 in Europe and 1 in Oceania) were committed to implementing this commitment. The level of concern around this issue was inversely proportional to the countries' population growth and directly proportional to the countries' income level.

233. Secondly, 78 per cent of countries expressed the need to "strengthen comprehensive habilitation and rehabilitation services and programmes", with no major regional differences observed, and 77 per cent of countries reported "creating employment opportunities for persons with disabilities". The number and percentage of countries that do not address the issue is small in Europe (8 per cent), Asia (10 per cent) and the Americas (19 per cent) and larger in Oceania (54 per cent) and Africa (38 per cent). This may suggest that a higher percentage of wealthier countries have committed themselves to addressing this issue during the past five years than poorer ones.

234. The issues of "developing infrastructure to ensure access on an equal basis with others" (68 per cent), "ensuring the same rights and access to sexual and reproductive health services, including HIV prevention" (65 per cent) and "guaranteeing equal and effective legal protection against discrimination" (60 per cent) are addressed by about 6 in 10 countries globally; the proportion is below the world average in Oceanic and African countries. **States should guarantee persons with disabilities, in particular young people, the right to health, including sexual and reproductive health and rights, as well as the right to the highest standard of care, ensuring that people with disabilities are partners in programming and implementation, and policy development, monitoring and evaluation, taking into account the structural factors that hinder the exercise of these rights.**

235. "Providing support to families caring for persons with disabilities" is addressed by 61 per cent of countries, and again the level of concern is proportional to the countries' income level and inversely proportional to the countries' population growth. Although 59 countries did not address this issue during the past five years, considerable differences are observed regionally. While 88 per cent of European countries reported addressing the issue, only 39 per cent of the countries in Oceania and 39 per cent of those in Africa (the majority) did so.

236. Finally, the issue which elicited the least commitment from countries was "promoting equality by taking all appropriate steps to ensure that reasonable accommodation is provided in all aspects of economic, social, political and cultural life", which was not a priority issue for 47.9 per cent of countries, most of them in Africa (23), Asia (23) and Oceania (10), and most of them poorer and fast-growing.

237. Increasing "accessibility and mobility" for persons with disabilities is among the top five priorities for half or more of countries at the lower end and middle of the income spectrum (low-income: 50 per cent; lower-middle-income: 59 per cent;

upper-middle-income: 66 per cent). Given the central importance of accessibility in building inclusive societies and sustainable and equitable development for all, this is an area that should receive greater attention and prioritization beyond 2014 and post-2015. Success in this area would significantly contribute to the full economic and social participation of persons with disabilities, many of whom live in developing countries and face accessibility and mobility challenges in their everyday life.

Human rights elaborations since the International Conference on Population and Development

Box 9

Persons with disabilities

Binding instruments. Recognized among the core international human rights instruments, the Convention on the Rights of Persons with Disabilities (2006; entry into force 2008) constitutes a tremendous advance in promoting the rights of persons with disabilities. The Convention recognizes persons with disabilities to include individuals with "long-term physical, mental, intellectual or sensory impairments", where such disabilities interact with additional barriers to prevent effective and equal participation in society. The Convention aims to "promote, protect and ensure the full and equal enjoyment of all human rights and fundamental freedoms by all persons with disabilities, and to promote respect for their inherent dignity". The Optional Protocol to the Convention on the Rights of Persons with Disabilities provides individuals with a communications mechanism to address instances where human rights have not been respected. Regionally, the Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities (1999; entry into force 2001) affirms that persons with disabilities are entitled to the full enjoyment of human rights and fundamental freedoms protected through international law.

Intergovernmental human rights outcomes. The Human Rights Council has adopted a series of resolutions on persons with disabilities, most recently resolution 22/3 on the work and employment of persons with disabilities (2013). Regional systems have elaborated rights of persons with disabilities in regional human rights instruments and documents.[143]

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[143] For more information on regional human rights systems and norms and standards relating to disability, see www.un.org/esa/socdev/enable/comp300.htm.

Government priorities: persons with disabilities

Economic empowerment and employment	65 per cent of Governments
Accessibility and mobility	57 per cent of Governments
Education	55 per cent of Governments
Social inclusion and rights	37 per cent of Governments
Development of programmes, policies, strategies, laws and the creation of institutions pertaining to persons with disabilities	28 per cent of Governments

238. When Governments were asked to identify the most relevant issues anticipated to receive priority in public policy relating to persons with disabilities, the top three priorities across 4 of 5 regions, and by a substantial margin, focused on economic empowerment, access and mobility, and education. Ten of 48 African countries, or 21 per cent, also listed "training for employment"[144] as a top five priority in a region above and beyond the distinct support for "economic empowerment and employment", affirming the importance of bringing disabled populations into the labour force in the region.

239. Equal access to "education" for disabled persons was a consistent priority for Governments around the world, but particularly for low-income countries (63 per cent). Discrimination faced by persons with disabilities in accessing the general education system, as well as the lack of an education system tailored to their needs, poses serious barriers to their self-reliance and access to equal opportunity.

240. Finally, a number of other priorities were frequently listed. For instance, more than half of low-income (53 per cent) and high-income OECD (52 per cent) Governments listed "social inclusion and rights"[145] as a key priority. "Rehabilitation and habilitation"[146] was one of the top five priorities for more than a third of Asian Governments (35 per cent), while "autonomy"[147] was prioritized by 21 per cent of European Governments.

F. Indigenous peoples

241. There are an estimated 370 million indigenous persons worldwide. Indigenous people have historically been, and continue to be, subject to social and political marginalization that has undercut their access to development. They have often been denied both the opportunity to sustain their own cultural heritage and the

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[144] Comprising all priorities relating to the provision of formal and informal training and skills to persons with disabilities to support a successful transition to the employment market.

[145] Comprising all priorities related to maximizing social inclusion and empowerment, and achieving equality of opportunity for all groups of persons with disabilities, without distinction of any kind, including all priorities that relate to addressing violence, neglect, abuse and discrimination against persons with disabilities, as well as unspecified human rights protections.

[146] Comprising all priorities related to strengthening and extending comprehensive habilitation and rehabilitation services and programmes for persons with disabilities.

[147] Comprising all priorities related to enabling persons with disabilities to live autonomously, that is, reducing their need for dependency and care.

opportunities commensurate with full social, political and economic integration into the prevailing political system.[148]

242. For many, structural discrimination included the violence of forced displacements, loss of homeland and property, separation of families, enforced loss of language and culture, the commodification of their cultures, and a disproportionate burden of the consequences of climate change and environmental degradation. Conditions of poverty are, for some groups, exacerbated by geographic distance and the remoteness of indigenous territories, itself a consequence of historic forced displacements.[148]

243. The Programme of Action of the International Conference on Population and Development affirmed the human rights of indigenous peoples in 1994. Later that year, the first International Decade of Indigenous Peoples was launched, followed by the Second International Decade of the World's Indigenous People in 2005. The past two decades have seen a notable growth in international actions aimed at protecting, promoting and fulfilling the rights of indigenous peoples. The United Nations Permanent Forum on Indigenous Issues was established in 2000. In 2001 the Commission on Human Rights decided to appoint a special rapporteur on the rights of indigenous peoples, whose mandate was renewed by the Human Rights Council, most recently in 2007. The same year, the United Nations Declaration on the Rights of Indigenous Peoples was adopted by the General Assembly (resolution 61/295), and the Expert Mechanism on the Rights of Indigenous Peoples was established by the Human Rights Council (resolution 6/36).

244. Despite the expansion of these concerted efforts to address the needs of indigenous peoples, significant disparities persist, with indigenous peoples experiencing significantly higher prevalence of tuberculosis, non-communicable diseases, poor mental health, and a shorter life expectancy compared to non-indigenous nationals of the same country. For example, more than 50 per cent of indigenous adults over age 30 worldwide suffer from type 2 diabetes. In the United States of America the risk of contracting tuberculosis is 600 times higher among Native Americans than in the general population. In Ecuador, the risk of contracting throat cancer is 30 times greater among indigenous persons than other nationals. The life expectancy gap between an indigenous child and a non-indigenous child in Nepal or Australia is 20 years, 13 years in Guatemala and 11 years in New Zealand.[148]

245. A study undertaken by the World Bank in 2005 on indigenous peoples in Latin America, some 28 million persons, found that "despite significant changes in poverty overall, the proportion of indigenous peoples in the region living in poverty — at almost 80 per cent — did not change much from the early 1990s to the early 2000s",[149] with poverty rates 7.9, 5.9 and 3.3 times higher among indigenous relative to non-indigenous peoples, in Paraguay, Panama and Mexico, respectively.[150]

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[148] *State of the World's Indigenous Peoples* (United Nations publication, Sales No. 09.VI.13).

[149] H. A. Patrinos and E. Skoufias, *Economic Opportunities for Indigenous Peoples in Latin America* (Washington, D.C., World Bank, 2007).

[150] Economic Commission for Latin America and the Caribbean (ECLAC), on the basis of J. L. Machinea and M. Hopenhayn, "La esquiva equidad en el desarrollo latinoamericano: una visión estructural, una aproximación multifacético" (United Nations publication, Sales No. S.05.II.G.158), cited in *Social Panorama of Latin America* (United Nations publication, Sales No. E.06.II.G.133), p. 150.

246. **States should guarantee indigenous peoples' right to health, including their sexual and reproductive health and rights, as well as their rights to both the highest standard of care and the respectful accommodation of their own traditional medicines and health practices, especially as regards reducing maternal and child mortality, considering their socio-territorial and cultural specificities as well as the structural factors that hinder the exercise of these rights.**

247. In its actions and objectives, the Programme of Action called on Governments to address the specific needs of indigenous peoples, including ensuring their access to services and full participation, and protecting, promoting and fulfilling their right to development, including their integration into national censuses.

248. Among respondents to the global survey, only a small proportion of countries reported having addressed the concerns of indigenous peoples during the past five years; this was consistent across all regions. No more than two thirds of reporting countries affirmed having government policies, budgets and implementation measures to meet the needs of indigenous peoples, and responses on this question were often provided by fewer than half of all countries in each region. This low response rate most likely reflects the fact that many countries do not recognize "indigenous peoples" living within their national boundaries.

249. The most positive response was with regard to education. Sixty-seven per cent of Governments stated that they had policies, budgets and implementation measures to ensure indigenous people access to "all levels and forms of public education without discrimination", but only 59 per cent had policies for creating access to education in a person's "own language and respecting their culture". Just under half of Governments (49 per cent) reported addressing the issue of "creating different work opportunities for indigenous peoples without discrimination" during the past five years. Just over half of the reporting countries (56 per cent) had addressed the issue of providing culturally appropriate "sexual and reproductive health care, including HIV prevention services" for indigenous peoples.

250. Regarding issues of governance, 58 per cent of countries reported having policies, budgets and implementation measures for "instituting concrete procedures and mechanisms for indigenous peoples to participate", 52 per cent reported that they had addressed the issue of "protecting and restoring the natural ecosystems on which indigenous communities depend", and half (50 per cent) had policies, budgets and implementation measures that addressed "enabling indigenous peoples to have tenure and manage their lands". The issue addressed by the smallest proportion of countries (31 per cent) was "seeking free, prior and informed consent of indigenous peoples in trade agreements [and] foreign direct investment agreements" affecting indigenous peoples.

251. **States should respect and guarantee the territorial rights of indigenous peoples, including those of peoples living in voluntary isolation and those in the initial phase of contact, with special attention to the challenges presented by extractive industries and other global investments, mobility and forced displacements, and design policies that respect the principle of free, prior and informed consent on matters that affect these peoples, pursuant to the provisions of the United Nations Declaration on the Rights of Indigenous Peoples.**

Human rights elaborations since the International Conference on Population and Development

Box 10

Indigenous peoples

Intergovernmental human rights outcomes. Following the International Conference on Population and Development, a number of international human rights instruments have addressed the rights of indigenous peoples. The landmark United Nations Declaration on the Rights of Indigenous Peoples (2007) states that "indigenous peoples have the right to the full enjoyment, as a collective or as individuals, of all human rights and fundamental freedoms as recognized in the Charter of the United Nations, the Universal Declaration on Human Rights and international human rights law".

Government priorities: indigenous peoples

Education	55 per cent of Governments
Economic empowerment and employment	36 per cent of Governments
Political empowerment and participation	33 per cent of Governments
Language, culture and identity	32 per cent of Governments
Land and territory	30 per cent of Governments
Social protection	30 per cent of Governments

252. Globally, 69 of the 176 Governments responding to the global survey answered the question on priorities for indigenous peoples: 23 in the Americas, 18 in Asia, 15 in Africa, 7 in Europe and 6 in Oceania.

253. In the Americas, after "education", which was indicated to be a priority by 14 of the 23 responding Governments, the next most frequently mentioned priorities were "political empowerment and participation" (12 Governments) and "land and territory" (10 Governments). These were followed by "social protection" (9 Governments), "health care (other than sexual and reproductive health)"[151] (9 Governments) and "development of policies, programmes, strategies, laws/creation of institutions"[152] (8 Governments). Hence, the key focuses for the region are capabilities and security, including education, health care, land and ways to secure them, particularly through political participation.

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[151] Comprising all priorities related to improving the provision of health care for indigenous peoples, with the exception of sexual and reproductive health and HIV care. This includes measures such as the provision of culturally appropriate, affordable, accessible and quality health care to meet the needs of indigenous peoples.

[152] Comprising all priorities that address the above, where the priority did not specify a particular sector.

254. In Asia, "education" for indigenous persons was also the top priority listed (11 of the 18 responding Governments) followed by "economic empowerment of employment" (9 Governments), suggesting the importance of accessing income-generating activities by indigenous persons. Prioritized by a smaller number of Governments, the issues "political empowerment and participation", "language, culture and identity" and "health care (other than sexual and reproductive health)" all garnered the same level of support (5 Governments).

255. In Africa, contrary to global and regional trends, "economic empowerment and employment" was the most frequently mentioned priority (8 of the 15 responding Governments) and the only priority mentioned by more than half of Governments. "Education" (7 Governments) and "language, culture and territory" (6 Governments) were the second and third most important priorities in the region.

256. **States should adopt, in conjunction with indigenous peoples, the measures needed to ensure that all indigenous persons enjoy protection from, and full guarantees against, all forms of violence and discrimination, and take measures to ensure that their human rights are respected, protected and fulfilled.**

257. **States should respect and implement the provisions of the United Nations Declaration on the Rights of Indigenous Peoples as well as the Indigenous and Tribal Peoples Convention, 1989 (No. 169) of the International Labour Organization, and call on those countries that have not already done so to sign and ratify the Convention; adapting legal frameworks and formulating the policies necessary for their implementation, with the full participation of indigenous peoples, including those who live in cities.**

G. Non-discrimination applies to all persons

258. The Programme of Action affirmed human rights principles related to equality and non-discrimination established in the Universal Declaration of Human Rights (1948), the International Covenant on Civil and Political Rights (1966) and the International Covenant on Economic, Social and Cultural Rights (1966), and elaborated in other international human rights instruments such as the International Convention on the Elimination of All Forms of Racial Discrimination (1965) and in the Declaration on the Rights of Persons Belonging to National or Ethnic, Religious and Linguistic Minorities (1992). Yet many people throughout the world continue to suffer from discrimination, a fact affirmed at the regional meetings on the International Conference on Population and Development beyond 2014.

259. The operational review showed that persons with diverse sexual orientations and gender identities in parts of the world suffer from the risk of harassment and physical violence. The outcomes of the regional reviews reinforced the importance of the principles of freedom and equality in dignity and rights as well as non-discrimination. Structural violence in the form of homonegativity marginalizes and dehumanizes persons of diverse sexual orientation and gender identity, hindering their capacity to fully contribute to society, and denying them the civil

rights that are typically afforded to other persons.[153] The commitment to individual well-being cannot coexist with tolerance of hate crimes or any other form of discrimination against any person.

260. In her report to the Human Rights Council on the subject (A/HRC/19/41), the High Commissioner for Human Rights noted that the Inter-American and African human rights systems have both reported upsurges in violence against sexual minorities, and the Council of Europe found that hate-motivated violence against lesbian, gay, bisexual, and transgender persons occurs in all its member States. The report noted that "young [lesbian, gay, bisexual and transgender] people and those of all ages who are seen to be transgressing social norms are at risk of family and community violence". Discrimination is compounded by the fact that 76 countries worldwide continue to criminalize consensual, same-sex behaviour,[154] and new research underscores a relationship between laws restricting the civil rights of persons of diverse sexual orientations and gender identities, and their mental health

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[153] W. B. Bostwick and others, "Dimensions of sexual orientation and the prevalence of mood and anxiety disorders in the United States", *American Journal of Public Health*, vol. 100, No. 3 (2010), pp. 468-475; S. D. Cochran and others, "Mental health and substance use disorders in Latino and Asian American lesbian, gay and bisexual adults", *Journal of Consulting and Clinical Psychology*, vol. 75, No. 5 (2007), pp. 785-794; S. D. Cochran, V. M. Mays and J. G. Sullivan, "Prevalence of mental disorders, psychological distress, and mental health services use among lesbian, gay and bisexual adults in the United States", *Journal of Consulting and Clinical Psychology*, vol. 71, No. 1 (2003), pp. 53-61; R. de Graaf, T. G. Sandfort and M. Have, "Suicidality and sexual orientation: differences between men and women in a general population-based sample from the Netherlands", *Archives of Sexual Behavior*, vol. 35, No. 3 (2006), pp. 253-262; R. H. DuRant, D. P. Krowchuk and S. H. Sinal, "Victimization, use of violence, and drug use at school among male adolescents who engage in same-sex sexual behaviour", *Journal of Pediatrics*, vol. 133, No. 1 (1998), pp. 113-118; A. H. Faulkner and K. Cranston, "Correlates of same-sex sexual behavior in a random sample of Massachusetts high school students", *American Journal of Public Health*, vol. 88, No. 2 (1998), pp. 262-266; R. Garofalo and others, "The association between health risk behaviors and sexual orientation among a school-based sample of adolescents", *Pediatrics*, vol. 101, No. 5 (1998), pp. 895-902; R. Garofalo and others, "Sexual orientation and risk of suicide attempts among a representative sample of youth", *Archives of Pediatrics and Adolescent Medicine*, vol. 153, No. 5 (1999), pp. 487-493; D. M. Fergusson, L. J. Horwood and A. L. Beautrais, "Is sexual orientation related to mental health problems and suicidality in young people?", *Archives of General Psychiatry*, vol. 56, No. 10 (1999), pp. 876-880; A. P Haas and others, " Suicide and suicide risk in lesbian, gay, bisexual, and transgender populations: review and recommendations", *Journal of Homosexuality*, vol. 58, No. 1 (2011), pp. 10-51; M. King and others, "A systematic review of mental disorder, suicide, and deliberate self-harm in lesbian, gay, and bisexual people", *BMC Psychiatry*, vol. 8 (August 2008); R. M. Mathy, "Suicidality and sexual orientation in five continents: Asia, Australia, Europe, North America, and South America", *International Journal of Sexuality and Gender Studies*, vol. 7, Nos. 2-3 (2002), pp. 215-225; G. Remafedi, "Suicidality in a venue-based sample of young men who have sex with men", *Journal of Adolescent Health*, vol. 31, No. 4 (2002), pp. 305-310; S. T. Russell and K. Joyner, "Adolescent sexual orientation and suicide risk: evidence from a national study", *American Journal of Public Health*, vol. 91, No. 8 (2001), pp. 1276-1281; J. P. Paul and others, "Suicide attempts among gay and bisexual men: lifetime prevalence and antecedents", *American Journal of Public Health*, vol. 92, No. 8 (2002), pp. 1338-1345.

[154] L. P. Itaborahy and J. Zhu, *State-sponsored Homophobia: A World Survey of Laws: Criminalisation, Protection and Recognition of Same-Sex Love*, 8th ed. (International Lesbian, Gay, Bisexual, Trans and Intersex Association, May 2013); available from http://old.ilga.org/Statehomophobia/ILGA_State_Sponsored_Homophobia_2013.pdf.

and well-being.[155] **States and the international community should express grave concern at acts of violence, discrimination and hate crimes committed against individuals on the grounds of their sexual orientation and gender identity. National leaders should advocate for the rights of all persons, without distinction of any kind.**

261. Many individuals and groups continue to be frequently exposed to discriminatory behaviour, including stigma, unfair treatment or social exclusion, owing to dimensions of their identity or circumstances. Discrimination may be compounded by laws criminalizing their behaviour; or laws that remain silent regarding their need for social protection. The persistence of discriminatory laws, or the unfair and discriminatory application of law, may reflect underlying stigma inflicted by powerful sectors of society, generalized public indifference and/or weak political leverage of those suffering discrimination.[156]

262. The global survey and the regional reviews and outcomes highlight the continuing gaps in fulfilling the human rights principle of non-discrimination affirmed at the International Conference on Population and Development in all cases where individuals or groups remain vulnerable, with direct effects on their health, including their risk of HIV/AIDS, and their exposure to violence, including sexual violence. The regional review outcomes contain various commitments to address these gaps, requiring States to protect the human rights of all individuals, including the right to gainful employment, residence, access to services and equality before the law.

263. **States should guarantee equality before the law and non-discrimination by adopting laws and policies to protect all individuals, without distinction of any kind, in the exercise of their social, cultural, economic, civil and political rights. States should also promulgate, where absent, and enforce laws to prevent and punish any kind of violence or hate crime, and take active steps to protect all persons, without distinction of any kind, from discrimination, stigma and violence.**

264. International human rights law reflects global commitments to ending discrimination against racial and ethnic minorities (see box 11 on non-discrimination). However, racial and ethnic minorities worldwide continue to face discrimination and marginalization that negatively impacts their health and freedoms and their access to education, employment, land, and natural resources.[157]

265. Mapping global racial and ethnic diversity requires tackling the complex challenge of defining and classifying what constitutes a distinct "ethnic or racial" group, categories that do not always accommodate consistent definitions. Ethnicity and race may be defined by self-identity or State-defined census categories, or they may reflect cultural, political, linguistic, phenotypical or religious affiliations, many

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[155] M. L. Hatzenbuehler and others, "The impact of institutional discrimination on psychiatric disorders in lesbian, gay, and bisexual populations, a prospective study", *American Journal of Public Health*, vol. 100, No. 3 (2010), pp. 452-459.

[156] Report of the International Conference on Population and Development Beyond 2014 International Conference on Human Rights, held in the Netherlands from 7 to 10 July 2013 (forthcoming).

[157] B. Walker, ed., *State of the World's Minorities and Indigenous Peoples 2012: Events of 2011 — Focus on Land Rights and Natural Resources* (London, Minority Rights Group International, 2012).

of which have marginal or no correspondence to genetic distinctions, existing largely as social categories.

266. Estimates of global ethnic diversity, for example, have documented 822 ethnic groups in 160 countries. Sub-Saharan Africa, which comprises approximately a quarter of the world's countries, has 351 ethnic groups, a striking 43 per cent of the world's culturally defined ethnic groups.[158]

267. The Minorities at Risk project has identified 183 minority groups experiencing political discrimination, of which 45 are most at risk because of repressive policies that exclude group members from political participation (see figure 16).[159]

268. Historic and sustained, discrimination can often lead to intergenerational cycles of poverty and disadvantage. For example, Afro-descendent populations in the Caribbean and Latin American face persistent conditions of poverty and social exclusion, as well as ongoing exploitation, through large-scale development projects that compromise their access to land and natural resources. In a wide range of countries, public health data illustrate persistent disparities in morbidity and mortality among minority racial and ethnic groups, reflecting the collective impact of numerous overlapping forms of discrimination in arenas such as access to health care, education, paid employment, nutrition and housing; socioeconomic and wealth disparities; and limited opportunities for advancement over the life course.[160]

269. **States should guarantee the full and equal participation of racial and ethnic minorities in social, economic and political life; guarantee free and safe integration in housing; lead an open dialogue on agreed public reconciliation and/or redress for past wrongs; and actively promote ties of mutual regard which are the backbone of a diverse civic life, such that men and women from different backgrounds may find with one another the fulfilment of their humanity.**

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[158] Ethnic groups were defined by several criteria, including (a) group membership reckoned primarily by descent by both members and non-members; (b) common group identity; and (c) distinguishing cultural features, such as common language, religion and customs (see J. D. Fearon, "Ethnic and cultural diversity by country", *Journal of Economic Growth*, vol. 8, No. 2 (2003), pp. 195-222).

[159] See www.cidcm.umd.edu/mar/; accessed 20 September 2013.

[160] B. Walker, ed., *State of the World's Minorities and Indigenous Peoples 2012: Events of 2011*; D. R. Williams and C. Collins, "U.S. socioeconomic and racial differences in health: patterns and explanations", *Annual Review of Sociology*, vol. 21 (1995), pp. 349-386, WHO, *WHO's Contribution to the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance: Health and Freedom from Discrimination*, Health and Human Rights Publication Series, No. 2. (August 2001); available from www.who.int/hhr/activities/q_and_a/en/Health_and_Freedom_from_Discrimination_English_699KB.pdf.

Human rights elaborations since the International Conference on Population and Development

Box 11

Non-discrimination

Binding instruments. The Optional Protocol to the International Covenant on Economic, Social and Cultural Rights (2008; entry into force 2013) was adopted by States "[n]oting that the Universal Declaration of Human Rights proclaims that all human beings are born free and equal in dignity and rights and that everyone is entitled to all the rights and freedoms set forth therein, without distinction of any kind, such as race, colour, sex, language, religion, political or other opinion, national or social origin, property, birth or other status". The Optional Protocol established a complaint and inquiry mechanism for persons who believe their economic, social and cultural rights have been violated, advancing human rights principles relating to non-discrimination and providing individuals with a mechanism to register rights violations.

Intergovernmental human rights outcomes. Non-discrimination is a special focus of the Office of the United Nations High Commissioner for Human Rights. Rights related to non-discrimination are elaborated in numerous instruments and are monitored by the Human Rights Council through special rapporteurs, independent experts and working groups, committees and forums that strive to combat discrimination and ensure the application of human rights to particular cases and/or issues.[161] Relevant resolutions include Council resolution 17/19 on human rights, sexual orientation and gender identity (2011), the first United Nations resolution on sexual orientation, in which the Council expressed grave concern at violence and discrimination based on sexual orientation and gender identity. In 2005 the Commission on Human Rights adopted resolution 2005/85 on the protection of human rights in the context of HIV/AIDS.

Other intergovernmental outcomes. The Durban Declaration and Programme of Action (2001) of the World Conference against Racism, Racial Discrimination, Xenophobia and Related Intolerance recognized and affirmed that "a global fight against racism, racial discrimination, xenophobia and related intolerance and all their abhorrent and evolving forms and manifestations is a matter of priority for the international community" and "that everyone is entitled to a social and international order in which all human rights can be fully realized for all, without any discrimination".

270. Migratory flows are more visible and more diverse than ever before, with profound socioeconomic impacts at both destination and origin. Yet migrants are frequently stigmatized and their risk of social discrimination remains high.

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[161] For additional information on United Nations activities related to human rights and non-discrimination see www.ohchr.org/EN/Issues/Discrimination/Pages/discrimination.aspx.

Ratification of conventions on migrants' rights has been limited and uneven. International protocols on the trafficking and smuggling of people, focused mainly on criminalizing trafficking, suppressing organized crime and facilitating orderly migration, have garnered broad support. By comparison, the ILO conventions seeking to promote minimum standards for migrant workers have received less widespread endorsement. The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990; entry into force 2003) has been ratified by only 47 countries to date, and the number of signatories is particularly low among countries with higher levels of migration or emigration.[162] **States should ensure that migrants are able to realize the fundamental human rights of liberty, security of person, freedom of belief and protection against forced labour and trafficking, and full rights in the workplace, including equal pay for equal work and decent working conditions, as well as equal access to basic services, particularly equal access to education, health, including sexual and reproductive health services, and support for integration for migrant children.**

271. While the negative effects of migration are generally assessed to be small, negative public attitudes towards migrants may nevertheless reflect fear of job displacement or reduction in wages, increase in the risk of crime, and added burden on the local public services.[163] As observed in the analysis of the World Values Survey, attitudes towards immigrants and foreign workers vary greatly between and within regions (figure 16), pointing to a variety of important contextual factors that include not only migration flows, but also political debates, media discourse, and the overall economic and cultural environment. In Latin America and the Caribbean the proportion of the population that shares intolerant attitudes towards immigrants and foreign workers is less than 10 per cent, the lowest of any region. Low proportions are also observed in most Western European countries; however, the range is wide, from 2 per cent in Sweden to 37 per cent in France. In Eastern Europe the proportion of the population sharing intolerant attitudes varies from 14 per cent in Poland to 32 per cent in the Russian Federation, while in Asia it varies from 20 per cent in China to 66 per cent in Jordan.[164]

272. Changes in attitudes towards immigrants and foreign workers over the past 5-10 years have been mixed in all regions. Of 24 countries with available trend data, more tolerant attitudes over time were observed in eight countries and less tolerant attitudes in nine countries, with the remaining seven countries showing no statistically significant changes within the past decade.[164] **More active efforts, including by training relevant law enforcement officials, are needed to combat discrimination, reduce misinterpretation of migration in public and political discourse, address social tensions and prevent violence against migrants.**

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[162] International Organization for Migration (IOM), *World Migration Report 2011: Communicating Effectively about Migration* (Geneva, 2011); *Human Development Report 2009: Overcoming Barriers — Human Mobility and Development* (United Nations publication, Sales No. E.09.III.B.1).

[163] *Human Development Report 2009: Overcoming Barriers — Human Mobility and Development.*

[164] Data from World Values Surveys (www.worldvaluessurvey.org/), downloaded and analysed 20 August 2013.

273. HIV-related stigma acts as a barrier to prevention, testing, disclosure, treatment and care.[165] The People living with HIV Stigma Index has shown that in a number of countries people living with HIV reported being denied access to health services and employment because of their HIV status.[166] Stigma is manifested in many forms, including physical, social and institutional stigma, contributing to isolation from family and community; experiences of violence; reduced participation in economic and social life; and poor physical and mental health outcomes.[167] Persecution of persons living with HIV, including through laws that criminalize HIV non-disclosure, exposure, and/or transmission,[168] creates a climate of fear that undermines human rights, and efforts to encourage people to seek HIV prevention, testing, treatment and social support.[169] **States should respect, protect and promote the human rights of all people living with HIV and enact protective laws facilitating access to health and social services to ensure that all persons living with, and at risk of, HIV can live free from stigma and discrimination.**

274. According to the latest available data from the World Values Surveys covering 48 countries, the proportion of the population that expressed intolerant attitudes towards persons with HIV and AIDS was higher than the proportion expressing intolerance towards immigrant or foreign workers, or towards persons of a different race (see figure 16). More tolerant attitudes were evident in high-income countries, in Latin America and the Caribbean, and in selected countries in Africa and Asia. In more than a quarter of the countries, most of them located in Asia and Eastern Europe, more than 50 per cent of respondents expressed intolerant attitudes. Several such countries also scored high on intolerance towards other population groups, suggesting that intolerant attitudes tend to cluster around multiple types of "difference".[164]

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[165] Q. A. Karim and others, "The influence of AIDS stigma and discrimination and social cohesion on HIV testing and willingness to disclose HIV in rural KwaZulu-Natal, South Africa", *Global Public Health*, vol. 3, No. 4 (2008), pp. 351-365; H. Brou and others, "When do HIV-infected women disclose their HIV status to their male partner and why? A study in a PMTCT programme, Abidjan", *PLoS Medicine*, vol. 4, No. 12 (2007); L. D. Bwirire and others, "Reasons for loss to follow-up among mothers registered in a prevention-of-mother-to-child transmission program in rural Malawi", *Transactions of the Royal Society of Tropical Medicine and Hygiene*, vol. 102, No. 12 (2008), pp. 1195-1200.

[166] Analysis of surveys conducted using the People living with HIV Stigma Index (www.stigmaindex.org), presented in UNAIDS, Global Report: *UNAIDS Report on the Global AIDS Epidemic 2013* (Geneva, 2013).

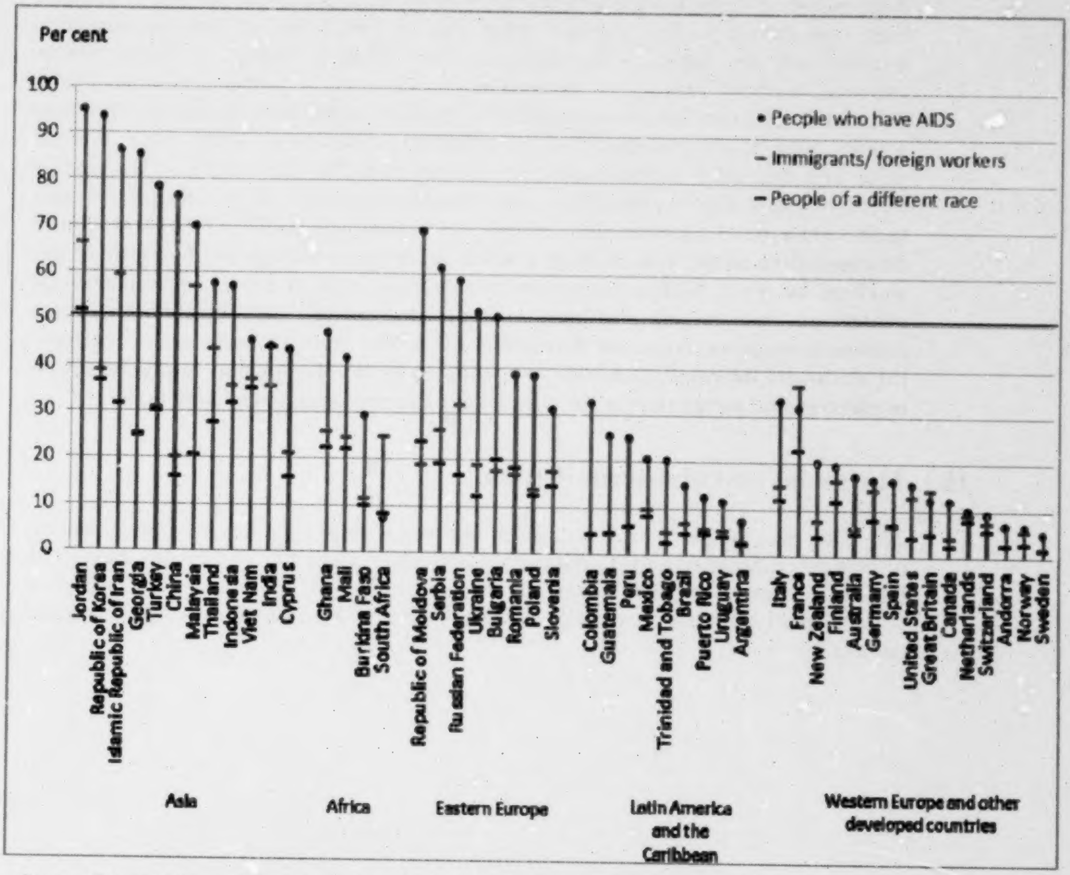
[167] J. Ogden, J. and L. Nyblade, *Common at Its Core: HIV-Related Stigma across Contexts* (Washington, D.C., International Center for Research on Women, 2005); UNAIDS, *Global Report: UNAIDS Report on the Global AIDS Epidemic 2013*.

[168] UNAIDS, "Criminalisation of HIV non-disclosure, exposure and transmission: background and current landscape", revised background paper prepared for the Expert Meeting on the Science and Law of Criminalization of HIV Non-Disclosure, Exposure and Transmission, held at Geneva from 31 August to 2 September 2001.

[169] UNAIDS and UNDP, "Criminalization of HIV transmission", UNAIDS Policy Brief (Geneva, August 2008).

Figure 16

Public tolerance towards selected population groups by region, 2004-2009



Source: World Values Surveys (data downloaded and analysed on 20 August 2013).

Key: 0, absolute public tolerance; 100, absolute absence of public tolerance.

Note: Intolerance is measured in the World Values Surveys as the proportion of respondents who mentioned certain population groups when asked the question: "On this list are various groups of people. Could you please mention any that you would not like to have as neighbours?". The list included the following: people with a criminal record; people of a different race; heavy drinkers; emotionally unstable people; immigrant/foreign workers; people who have AIDS; drug addicts; and homosexuals. The same list was used for most countries covered by the World Values Surveys, but selected countries added to the list population groups specific to their country contexts.

275. Over the past two decades sex workers[170] have been the focus of many public health initiatives concerned with the spread of HIV and AIDS, but rarely have their own rights to health been acknowledged, nor their rights to social protection from

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[170] Sex workers include "female, male and transgender adults and young people [age 18-24] who receive money or goods in exchange of sexual services" (see UNAIDS, "Sex work and HIV/AIDS", UNAIDS Technical Update (Geneva, June 2002)).

poverty or violence.[171] With 116 countries criminalizing some aspect of sex work,[172] sex workers face deeply rooted stigma, as well as institutionalized discrimination through legal and policy environments that reinforce and exacerbate their vulnerabilities. Sex workers often live in conditions of extreme structural poverty and are highly vulnerable to often brutal violence, including sexual violence, without redress or protection.[173] Violence is linked to other health vulnerabilities, with female sex workers 13.5 times more likely to acquire HIV than women aged 15-49 globally.[171] Criminalization of sex work limits their political voice and collective representation,[174] thereby reducing their chances to improve their living and working conditions, gain financial security, adequately protect their health and expand opportunities for themselves and their families.[175] **States should decriminalize adult, voluntary sex work in order to recognize the right of sex workers to work without coercion, violence or risk of arrest; provide social protection and meaningful employment alternatives and opportunities for economic empowerment, so that individuals who wish to leave sex work have the ability to do so; and include sex workers in the design and implementation of policies and programmes for which they are the intended beneficiaries.**

H. The social cost of discrimination

276. The past 20 years have witnessed enormous leaps in scientific understanding of how discrimination and stigma impact both physical and mental health, as well as human performance. Such research affirms the extent and manner by which a climate of discrimination curtails the well-being and productivity of persons and nations.[176]

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[171] D. Kerrigan and others, *The Global HIV Epidemics among Sex Workers* (Washington, D.C., World Bank, 2013).

[172] Global Commission on HIV and the Law, *HIV and the Law: Risks, Rights and Health* (New York, United Nations Development Programme, 2012).

[173] WHO, "Violence against women and HIV/AIDS: critical intersections — violence against sex workers and HIV prevention", Information Bulletin Series, No. 3 (2005); UNAIDS, *UNAIDS Guidance Note on HIV and Sex Work* (Geneva, 2012).

[174] Open Society Foundations, "10 reasons to decriminalize sex work: a reference brief" (New York 2012).

[175] UNAIDS, *UNAIDS Guidance Note on HIV and Sex Work*.

[176] N. Krieger, "Embodying inequality: a review of concepts, measures, and methods for studying health consequences of discrimination", *International Journal of Health Services*, vol. 29, No. 2 (1999), pp. 295-352; E. A. Pascoe and L. Smart Richman, "Perceived discrimination and health: a meta-analytic review", *Psychological Bulletin*, vol. 135, No. 4 (2009), pp. 531-554; D. R. Williams, H. W. Neighbors and J. S. Jackson, "Racial/ethnic discrimination and health: findings from community studies", *American Journal of Public Health*, vol. 93, No. 2 (2003), pp. 200-208; D. R. Williams and S. A. Mohammed, "Discrimination and racial disparities in health: evidence and needed research", *Journal of Behavioral Medicine*, vol. 32, No. 1 (2009), pp. 20-47.

277. A growing body of research from around the world affirms that physical health, mental health and productivity are not only compromised by physical harassment, bullying or violence; similar effects are prompted by pervasive negative stereotypes, experience of stigma and fear of discrimination.[177] The costs to society of having a substantial proportion of citizens waging a sustained struggle for dignity and fundamental rights should concern political leaders, given the evident losses in terms of health, well-being and productivity and the potential for increased social instability where human suffering is not addressed. New thinking on the "cost of inaction" estimates the significant, and often hidden, consequences of failing to take appropriate action to address injustices and inequalities and underscores the high toll that such inaction extracts from communities, as illustrated below.[178]

278. In the area of women's health, birth outcomes are increasingly recognized as being responsive to conditions of stress due to discrimination against the mother.[179] A recent illustrative investigation of mothers in California compared birth outcomes before and after the terrorist attacks of 11 September 2001. Mothers with Arabic-sounding names had a significantly increased risk of preterm delivery and low birth weight over a six-month period after the attacks compared to the same period a year earlier, while those with the most ethnically distinctive names had the greatest risk of poor birth outcomes. No similar change in birth outcomes before and after 11 September was observed among mothers without Arabic-sounding names, providing strong evidence that the stress of anti-Arab sentiment in the period following 11 September compromised birth outcomes among mothers with Arabic names.[180]

279. Evidence of the effect of discrimination on performance and productivity is equally compelling. When middle-school boys in India were asked to perform a maze puzzle, there was no difference in performance between boys of all castes; however, when the boys' family name and caste were announced before a second

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[177] Williams and Jackson, "Racial/ethnic discrimination and health: findings from community studies"; S. J. Spencer, C. M. Steele and D. M. Quinn, "Stereotype threat and women's math performance", *Journal of Experimental Social Psychology*, vol. 35, No. 1 (1999), pp. 4-28; J. L. Smith and P. H. White, "An examination of implicitly activated, explicitly activated, and nullified stereotypes on mathematical performance: it's not just a women's issue", *Sex Roles*, vol. 47, Nos. 3-4 (2002), pp. 179-191.

[178] The cost of inaction, or the negative consequences to families, communities and society of failing to take appropriate action to address injustices and inequalities, has been applied to climate change, environmental issues, and children's well-being. The concept was applied to children's well-being through the Cost of Inaction Initiative launched at the François-Xavier Bagnoud Center for Health and Human Rights at Harvard University in 2008 (see S. Anand and others, *The Cost of Inaction: Case Studies from Rwanda and Angola* (Boston, Harvard University Press, 2012)). UNFPA explored the cost of inaction as applied to sexual and reproductive health and rights and gender inequality at an Expert Group Meeting on the cost of inaction in reproductive rights: linking sustainable development, human rights and sexual and reproductive health, held in New York on 7 and 8 October 2013.

[179] C. G. Colen and others, "Maternal upward socioeconomic mobility and black-white disparities in infant birthweight", *American Journal of Public Health*, vol. 96, No. 11 (2006), pp. 2032-2039; J. W. Collins Jr. and others, "Very low birthweight in African American infants: the role of maternal exposure to interpersonal racial discrimination", *American Journal of Public Health*, vol. 94, No. 12 (2004), pp. 2132-2138; S. Mustillo and others, "Self-reported experiences of racial discrimination and black-white differences in preterm and low-birthweight deliveries: the CARDIA study", *American Journal of Public Health*, vol. 94. No. 12 (2004), pp. 2125-2131.

[180] D. S. Lauderdale, "Birth outcomes for Arabic-named women in California before and after September 11", *Demography*, vol. 43, No. 1 (2006), pp. 185-201.

round of testing, there was a large and significant performance differential by caste, with low-caste boys underperforming. The announcement of caste in front of other boys had a debilitating effect on the performance of lower-caste boys.[181]

280. A daily struggle for dignity and against discrimination is a lived experience for millions of people around the world. Government support in that struggle is manifest in reported policies, budgets and programmes to protect specific populations from abuse, neglect and violence, and also in laws that respect, protect and guarantee the human rights of these populations. The evidence from the global survey suggests a world in which most countries recognize and protect their citizens, but not all countries, and not all population groups.

281. The overwhelming majority of countries (87 per cent) reported that they have addressed the issue of "preventing children's abuse and neglect and [providing] assistance to [child] victims of abuse, neglect or abandonment, including orphans" during the past five years. Protecting children as they attend school did not garner a similar level of support, with 59 per cent of countries reporting that they had addressed the issue of "improving the safety of pupils, especially girls, in and on their way to school". A higher proportion of countries addressed this issue in Asia (66 per cent) and Africa (63 per cent) than in Oceania (55 per cent), the Americas (54 per cent) and Europe (48 per cent). Similarly, actions "addressing gender-based violence and bullying in schools" have been addressed, budgeted and implemented by almost two thirds of countries (63 per cent); a larger share of countries in the Americas (83 per cent) have done so than in Africa (62 per cent), Europe (61 per cent), Asia (53 per cent) and Oceania (50 per cent).

282. With regard to explicitly addressing discrimination against persons other than children, the proportion of countries with policies, budgets and implementation measures in place is not encouraging (60 per cent or less), depending on the groups addressed. For example, 57 per cent of countries have addressed the issue of "preventing discrimination against older persons, especially widows", and 60 per cent have addressed the issue of "guaranteeing to persons with disabilities equal and effective legal protection against discrimination on all grounds".

283. The same proportion of countries have addressed, budgeted and implemented the issue of "protecting migrants against human rights abuses, racism, ethnocentrism and xenophobia" (60 per cent). Regionally, a higher proportion of countries address this issue in Asia (71 per cent) and the Americas (70 per cent) than in Europe (59 per cent), Africa (56 per cent) and Oceania (20 per cent). With regard to the legal and practical restrictions on the movement of people within countries, which include, among others, the need for a work permit, proof of identity, proof of employment or a legal address at the place of destination, the requirement that women be authorized by their husbands or legal guardians/tutors and restrictions based on HIV status, only four countries reported legal restrictions (two in Asia and two in Africa), four others reported practical restrictions (two in Asia and two in Africa), and nine reported both legal and practical restrictions (three in Africa, three in Asia, two in the Americas, and one in Oceania).

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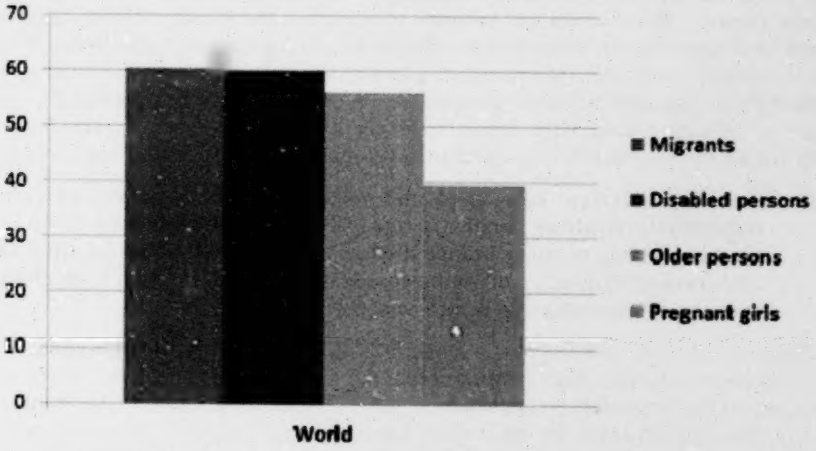
[181] K. Hoff. and P. Pandey, "Belief systems and durable inequalities: an experimental investigation of Indian caste", World Bank Policy Research Working Paper No. 3351 (Washington, D.C., June 2004; K. Hoff and P. Pandey, "Making up people: the effect of identity on preferences and performance in a modernizing society", World Bank Policy Research Working Paper No. 6223 (Washington, D.C., October 2012).

284. Unfortunately, only 40 per cent of countries have addressed the issue of "facilitating school completion for pregnant girls" during the past five years, a form of discrimination that is especially costly to society given the age of the young women involved and the importance of their education, not only to their own long-term prospects but also to the well-being of their children. This proportion decreases to 29 per cent among countries in Europe and 21 per cent in Asia, while it increases to 67 per cent in the Americas. This may be linked to the fact that Latin America and the Caribbean have the second-highest rate of adolescent pregnancies in the world.

Figure 17

Percentage of Governments addressing discrimination against migrants, disabled persons, older persons and pregnant girls



Source: Global survey on the International Conference on Population and Development beyond 2014.

Note: The commitments reported by Governments in the global survey do not necessarily reflect the extent to which relevant laws are upheld or enforced.

285. **Comprehensive measures are needed to ensure non-discrimination, equality and the realization of human potential for all population groups. States should address the multiple and overlapping forms of inequality, disempowerment and discrimination, through a commitment to equality and non-discrimination for all persons, without distinction of any kind, in the exercise of their social, cultural, economic, civil and political rights, including the right to gainful employment, residence and access to services, as well as the need to promulgate and enforce laws that take active steps to protect people from discrimination, stigma and violence.**

286. **States should adapt necessary legal frameworks and formulate policies, with the full participation of those who are discriminated against, including women, adolescents, older persons, persons with disabilities, indigenous persons, ethnic and racial minorities, migrants, persons living with HIV, persons of diverse sexual orientations and gender identities and sex workers, and with the participation of civil society throughout the process of design, implementation evaluation of those policies.**

I. Dignity and human rights: key areas for future action

1. Despite significant gains in poverty reduction and economic growth since the International Conference on Population and Development, economic inequalities have been increasing and threaten further progress towards sustainable development. Addressing these issues requires increased efforts to eradicate poverty and promote equitable livelihood opportunities.

287. Significant poverty reduction has occurred in the last two decades, yet 1.2 billion people are still living in extreme poverty, lacking fulfilment of basic needs, meaningful work, access to social protection, or public services in health and education. The current state of wealth inequality, where almost 70 per cent of adults possess only 3 per cent of the world's wealth, is unsustainable, as it threatens future economic growth, the cohesion and security of societies and the capacity of people to adapt and innovate in response to changing environmental conditions. The principal message of the International Conference — that the fulfilment of individual rights and capabilities is the foundation of sustainable development — is even more relevant today, with ample evidence that investments in substantive equality for all persons results in long-term development and population well-being.

2. The empowerment of women and girls and gender equality remain unfulfilled, requiring further actions to ensure women's leadership in public spheres, equality before the law and in practice, elimination of all forms of violence, and empowerment of women in exercising their sexual and reproductive health and rights.

288. Discrimination against women is evident in all societies, and women continue to have fewer opportunities than men to define the directions of their lives, exercise their human rights, expand their capabilities and elaborate their chosen contribution to society. Despite advances in legislation, harmful practices, such as child, early and forced marriage and female genital mutilation/cutting, remain prevalent in many countries. Despite gains in universal primary education for both sexes, adolescent girls are disproportionately excluded from lower and higher secondary education. In the labour market, women continue to be paid less than men for equal work and to be substantially overrepresented in vulnerable and informal employment where jobs are less secure and provide fewer benefits. Women and girls bear a disproportionate share of unpaid household labour. Women also remain substantially underrepresented in positions of power and decision-making in politics, business and public life.

289. Violence against women and girls continues to be one of the most prevalent forms of human rights violations worldwide, creating extreme insecurity with lifelong costs. United Nations agencies and researchers have made critical inroads into measuring violence in the past decade, exposing the startling extent to which sexual and domestic violence occurs, beginning early and affecting one in three women. Such efforts deserve all possible support, within and across countries, to strengthen routine monitoring; extend research into important unaddressed issues such as the number of people living in conditions of sustained fear; violence within schools, prisons and the military; the causes of violence; and the effectiveness of interventions and of laws and systems for the protection and recovery of victims and/or survivors.

3. Substantial investment is needed in the capabilities of children, adolescents and youth, while ensuring that every child and young person, regardless of circumstances, has access to quality pre-primary, primary and secondary education and comprehensive sexuality education holistically defined and consistent with their evolving capacities, and has a rapid, safe and productive transition from school to working life and adulthood.

290. Adolescents and youth are central to the development agenda of the developing countries in the coming two decades, because the proportion of the population entering the productive and reproductive years stands at the historically high level of over a quarter of the total population. These cohorts can, if provided with quality education and the opportunities to define their futures, secure their sexual and reproductive health and rights and delay the formation of their families, jump-start economic growth and spur the innovations needed for a sustainable future. Safeguarding the rights of young people and investing their human capital in development deserve urgent attention, including access to quality education and training linked to expanding sectors of the economy; sexual and reproductive health information, education and services; and participation in the design and evaluation of programmes for which they are the intended beneficiaries.

4. Active efforts are needed to eliminate discrimination and marginalization, and promote a culture of respect for all.

291. Many individuals and groups continue to be exposed to discrimination on the basis of dimensions of their identity or circumstances. The social cost of discrimination is high, with growing evidence that stigma and discrimination negatively affect every aspect of the lives of those who are impacted, including mental and physical health, childbearing and productivity. Public opinion research is a powerful instrument for advocacy, identifying where stigma and discrimination may be most entrenched, and therefore where individuals may be most vulnerable. With regard to public discrimination against women and intolerance towards racial and ethnic minorities, immigrants and foreign workers, and towards people living with HIV, the present report highlights variations in stigma between countries, and where trends are improving. The United Nations System Task Team on the Post-2015 United Nations Development Agenda has underscored the importance of public opinion data on attitudes; regular monitoring, in national statistics, of public values regarding sexism, ageism, racism and other forms of discrimination is recommended. The protection of the human rights of all individuals is crucial, requiring an enabling environment where people can exercise autonomy and choice, with all individuals, particularly women, adolescents and those belonging to other marginalized groups, empowered to claim their human rights.

III. Health

> "[R]eproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents and other consensus documents. These rights rest on the recognition of the basic right of all couples and individuals to decide freely and responsibly the number, spacing and timing of their children and to have the information and means to do so, and the right to attain the highest standard of sexual and reproductive health. It also includes their right to make decisions concerning reproduction free of discrimination, coercion and violence, as expressed in human rights documents."
>
> (Programme of Action, para. 7.3)

> "The objectives [in the primary health care and the health-care sector] are: (a) to increase the accessibility, availability, acceptability and affordability of health-care services and facilities to all people in accordance with national commitments to provide access to basic health care for all; (b) to increase the healthy life-span and improve the quality of life of all people, and to reduce disparities in life expectancy between and within countries."
>
> (Programme of Action, para. 8.3)

> "Implementation of key elements of the Programme of Action must be tied closely to a broader strengthening of health systems."
>
> Key actions for the further implementation of the programme of action of the International Conference on Population and Development (General Assembly resolution S-21/2), annex, para. 85))

292. The changes in global population health over the past two decades are striking in two ways: a dramatic aggregate shift in the composition of the global health burden towards non-communicable diseases and injuries, including those due to global ageing, and the persistence of communicable, maternal, nutritional and neonatal disorders (i.e., diseases of poverty) in sub-Saharan Africa and South Asia. Efforts to improve the quality and accessibility of sexual and reproductive health care since 1994 have led to significant improvements in many sexual and reproductive health indicators, with evidence of stronger government commitments to policy, budgeting and programmes for many of the most pressing sexual and reproductive health goals. Yet aggregate improvements mask significant inequalities both between and within countries, with far too many countries exhibiting progress among households in the upper household wealth quintiles, while progress is flat or marginal among poor households. The persistence of poor sexual and reproductive health outcomes among the poor, particularly in Africa and South Asia, underscores the near impossibility of further progress in the realization of health for all persons without sustained attention to strengthening the reach, comprehensiveness and quality of health systems. The number and distribution of skilled health workers, a vibrant knowledge sector and systems of public accountability are among the prerequisites of a rights-based health system and pivotal to future sustainable gains in sexual and reproductive health. This thematic section celebrates progress in many sexual and reproductive health outcomes since the International Conference on Population and Development, but underscores the continuing fragility of health systems for the poor and the unfulfilled right to sexual and reproductive health.

A. A human rights-based approach to health

293. Numerous United Nations and bilateral development agencies have defined a human rights-based approach to health as one that aims to realize the right to the highest attainable standard of health based on "a conceptual framework … that is normatively based on international human rights standards and operationally directed to promoting and protecting human rights".[182]

294. WHO has proposed that a human rights-based approach to health is based on seven key principles: availability, accessibility, acceptability, quality of facilities and services, participation, equality and non-discrimination, and accountability.[183] Further, the Human Rights Council, in resolution 18/2 on preventable maternal mortality and morbidity, recognized that "a human rights-based approach to eliminate preventable maternal mortality and morbidity is an approach underpinned by the principles of, inter alia, accountability, participation, transparency, empowerment, sustainability, non-discrimination and international cooperation". As these principles were affirmed in the Programme of Action, the operational review afforded the opportunity to address the question whether achievements in health since 1994, particularly the provision of services and underlying social determinants affecting the sexual and reproductive health of women and girls, reflect the expansion and strengthening of a human rights-based approach to health.

B. Child survival

295. There have been significant improvements in the survival of children since 1990. The global under-five mortality rate has dropped from 90 deaths per 1,000 live births in 1990 to 48 in 2012. All regions made substantial progress, many by 50 percentage points or more. Sub-Saharan Africa has the highest child mortality rate (98 per 1,000 live births in 2012) and increasingly concentrates the largest share of all under-five deaths (nearly half of global under-five deaths). South Asia also continues to have both a high rate of under-five mortality (58 deaths per 1,000 live births) and a large number of total deaths (nearly a third of the global under-five deaths).[184]

296. Countries in all regions and all income levels have made progress in saving children's lives. While low-income countries tend to have the highest rates of under-five mortality, a large reduction in child mortality has been observed recently for several low-income countries including Bangladesh, Cambodia, Eritrea, Ethiopia, Guinea, Liberia, Madagascar, Malawi, Mozambique, Nepal, the Niger, Rwanda, Uganda and the United Republic of Tanzania.[185]

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[182] Concept of a human rights-based approach adopted by the United Nations Population Fund (see UNFPA, *A Human Rights-Based Approach to Programming: Practical Implementation Manual and Training Materials* (2010)).

[183] F. Bustreo and others, *Women's and Children's Health: Evidence of Impact of Human Rights* (Geneva, World Health Organization, 2013), p. 13.

[184] United Nations Inter-Agency Group for Child Mortality Estimation, *Levels and Trends in Child Mortality: Report 2013 — Estimates Developed by the UN Inter-Agency Group for Child Mortality Estimation* (New York, United Nations Children's Fund, 2013).

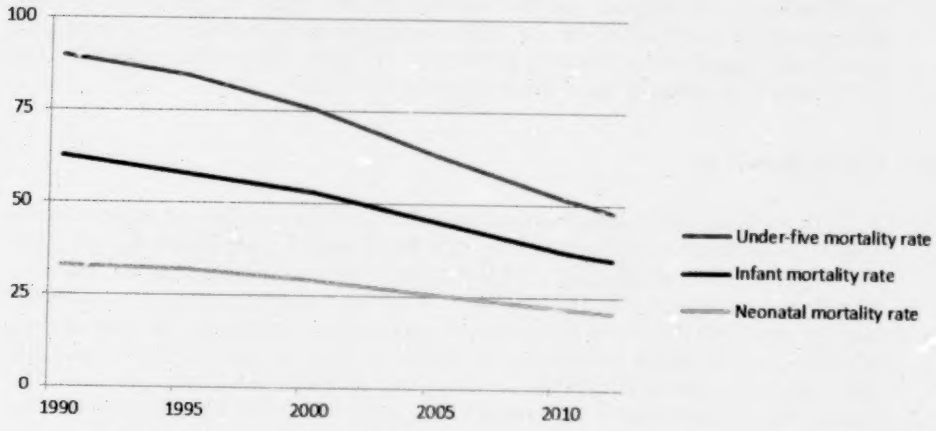
[185] UNICEF, *Committing to Child Survival: A Promise Renewed — Progress Report 2013* (New York, 2013).

297. The proportion of neonatal deaths among total under-five deaths has been increasing because declines in mortality rates among neonates have been slower than those for older children in all regions (see figure 18).[184] Neonatal survival is highly dependent on the overall health and the continuity of clinical care of mothers in the preconception period, during pregnancy, at delivery and during the postpartum period. To improve neonatal survival women need access to good nutrition before, during and after pregnancy; prevention and treatment of malaria during pregnancy; syphilis screening and treatment; management of birth complications; adequate treatment of infections in the neonate; and routine support throughout the neonatal period.[186] In 2012, 34 per cent of neonatal deaths were caused by complications of preterm birth, and a quarter by sepsis and meningitis (12 per cent), pneumonia (10 per cent) or diarrhoea (2 per cent).[184]

Figure 18

Global under-five, infant and neonatal mortality rates, 1990-2010

(per 1,000 live births)



Source: Childinfo database. Available from www.childinfo.org/mortality_tables.php (accessed on 25 October 2013).

298. In 2012 neonatal deaths represented 44 per cent of under-five deaths at the global level.[184] Sub-Saharan Africa maintains the highest neonatal mortality rate (32 deaths per 1,000 live births), and accounts for 38 per cent of global neonatal deaths.[184] The region also has the highest maternal mortality rate (500 maternal deaths per 10,000 live births), underscoring the close link between maternal and neonatal survival.[187] Neonatal deaths in the region represent a lower share of all child deaths (34 per cent), because of the still-high mortality rates for older children in sub-Saharan Africa.[184]

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[186] United Nations Inter-Agency Group for Child Mortality Estimation, *Levels and Trends in Child Mortality: Report 2013*; UNICEF, *Committing to Child Survival: A Promise Renewed*; Partnership for Maternal, Newborn and Child Health, *Opportunities for Africa's Newborns: Practical Data, Policy and Programmatic Support for Newborn Care in Africa* (World Health Organization, 2006).

[187] WHO and others, *Trends in Maternal Mortality: 1990-2010* (see footnote 6 above).

299. A significant proportion of under-five deaths are due to preventable causes and treatable diseases.[184] Although declining, infectious diseases and conditions still account for almost two thirds of the global total of under-five deaths. Pneumonia and diarrhoea, followed by malaria, remain the major causes of child death and account for 17 per cent, 9 per cent and 7 per cent respectively of all under-five deaths.[188]

300. Children are at greater risk of dying before age 5 if they are born in rural areas, in poor households, or to a mother without basic education.[185] In 2012 it was estimated that undernutrition was a contributing factor for approximately 45 per cent of under-five deaths at the global level.[184]

301. Yet some of these disparities are decreasing. For example, evidence from selected sub-Saharan African, Asian and Latin American countries suggests that neonatal, post-neonatal and child mortality declined between the 1990s and early 2000s in both rural and urban areas, including in urban slums, with the larger decline observed in rural areas. Also, under-five mortality rates declined in both poorer and wealthier households, and disparities in under-five mortality between the richest and the poorest households have declined in most regions of the world. The exception is sub-Saharan Africa, where disparities in under-five mortality rates by household wealth quintile have increased slightly.[185]

C. Sexual and reproductive health and rights

302. In 1990, sexual and reproductive health represented 14.4 per cent of the global burden of disease, which is 14 per cent of all disability-adjusted life years lost, a proportion virtually unchanged in 2010.[189] The burden has declined in most regions but increased substantially in Africa (see figure 19), largely reflecting the added burden of HIV and AIDS since 1990. The burden remains highest in Africa and South Asia, and the degree to which these two regions lag behind the others in bearing the burden of sexual and reproductive health conditions is larger in 2010 than it was in 1990.

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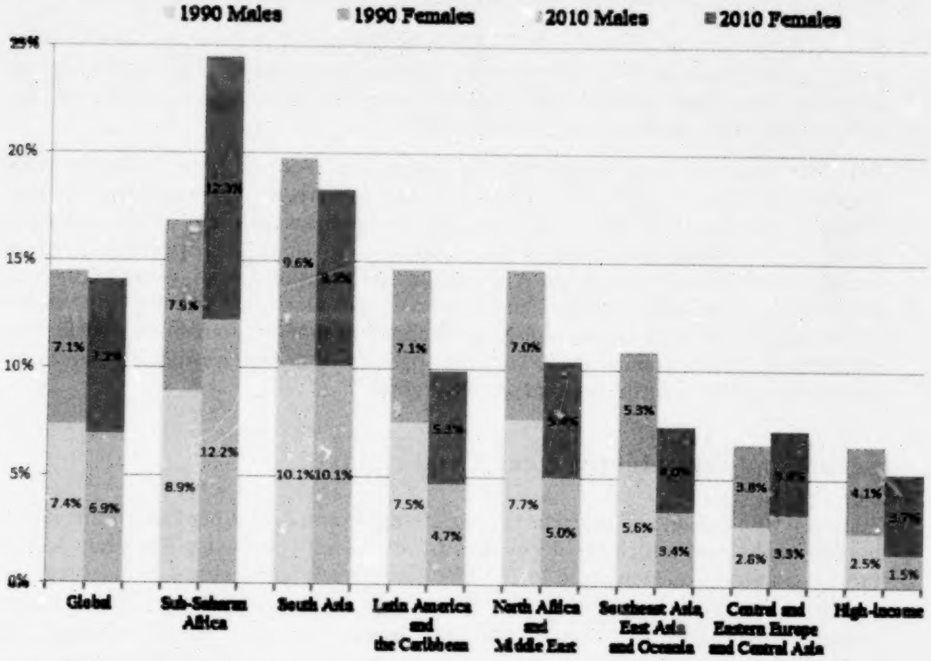
[188] See UNICEF, Childinfo database (www.childinfo.org/mortality_underfive.php).

[189] The disability-adjusted life year remains the one measure that offers us a chance to estimate — with reasonable confidence — the relative burden of sexual and reproductive health as a proportion of the overall global burden of disease, by sex and region.

Figure 19

Total disability-adjusted life years attributed to sexual and reproductive health conditions among males and females (all ages), worldwide and by region, 1990-2010



Source: WHO, Global Burden of Disease database, 2013.

303. There has been a significant change in the composition of the sexual and reproductive health burden over the intervening 20 years, with a decline in the disability-adjusted life years lost to perinatal conditions, syphilis and maternal mortality since 1990 compensated for by increases in disability-adjusted life years lost to HIV/AIDS in 2010.

304. The gains in maternal health and other dimensions of sexual and reproductive health and rights during the past 20 years reflect advances in many distinct goals of the Programme of Action, for example, in technical advances relating to childbirth, access to contraception to avert unwanted pregnancies, and proximate factors such as gains in women's education and social, legal and political empowerment. While many sexual and reproductive health rights remain unfulfilled, the gains nonetheless underscore the dramatic redirection of development programmes that occurred at the International Conference on Population and Development.

1. A troubled history

305. A substantial proportion of sexual and reproductive health-related investments in the two decades preceding 1994 had focused on population control and contraceptive innovations. Those investments had yielded an unprecedented expansion of new contraceptive products, variations of which are now part of the modern contraceptive market: injectable Depo-Provera, Cyclofem and Mesigyna;

low-dose combined oral contraceptives and the progesterone mini-pill; improved copper- and steroid-releasing intrauterine devices; an entirely new delivery system through implants; and a female condom. Combined injections for men were under early development in 1994, and a contraceptive vaccine was facing scientific hurdles and resistance by women's groups in almost equal measure.

306. The political atmosphere in 1994 was one of substantial mistrust on the part of women's groups towards the agencies, private companies and Governments developing and evaluating these new contraceptive methods, as well as those delivering contraceptives and related services to women. The provider-controlled nature of many new products heightened the potential for coercion and involuntary fertility control, and women's groups became increasingly adept at sharing information on a global scale about cases of such human rights violations, some of which were occurring systematically and on a national scale. In the decade prior to the International Conference, the escalation of incidents in which women's rights were transgressed by family planning programmes suggested a sector-wide subordination of women's health and human rights to population control imperatives.[190]

307. Disputes over Norplant, depot medroxyprogesterone acetate (DMPA, branded as Depo-Provera) and quinacrine are illustrative. In 1987, the ministry of health in one country embarked upon a Norplant campaign, becoming the world's largest contraceptive implant programme. In the first year there were 145.826 new users, with the number of insertions rising to 398,059 in 1989-1990. By 1997, approximately 4 million women in the country had had the six rods of Norplant inserted, with 62 per cent of insertions done by mobile clinics. However, this ambitious programme focused more on insertions than on follow-up, failing to account for the necessary staffing and training for removals. All too frequently, women had to make numerous removal requests before they were attended to, and many women, suffering from side effects about which they had not been counselled, were charged fees for early removals, in contrast to the free, or highly subsidized, insertions.[191]

308. The long-delayed United States Food and Drug Administration approval of the three-month injectable contraceptive Depo-Provera reflected another case of wide-scale institutional disregard for the health, safety and reproductive rights of poor women, in this case during the clinical trial of DMPA at the Grady Medical Center in Atlanta, Georgia, from 1968 to 1979. While DMPA was gaining approval in a growing number of countries worldwide, the trials conducted by the Food and Drug Administration were based on clinical data from 14,000 predominantly rural,

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[190] B. Hartmann, *Reproductive Rights and Wrongs: The Global Politics of Population Control* (Boston, South End Press, 1995), chap. 6; C. Garcia-Moreno and A. Claro, "Challenges from the women's health movement: women's rights versus population control", in *Population Policies Reconsidered: Health, Empowerment, and Rights*, G. Sen, A. Germaine and L. C. Chen, eds. (Cambridge, Harvard University Press, 1994), pp. 47-62.

[191] Ninuk Widyantora, "The story of Norplant® implants in Indonesia", *Reproductive Health Matters*, vol. 2, No. 3 (May 1994), pp. 20-28; J. Tuladhar, P. J. Donaldson and J. Noble, "The introduction and use of Norplant® implants in Indonesia", *Studies in Family Planning*, vol. 29, No. 3 (September 1998), pp. 291-299; J. Bereiter, "Controversial contraception" (book review), *Canadian Family Physician*, vol. 41 (November 1995), pp. 1967-1969; A. A. Fisher and others, "An assessment of Norplant® removal in Indonesia", *Studies in Family Planning*, vol. 28, No. 4 (December 1997), pp. 308-316.

African American, low-income women.[192] When reviewed by the Administration, the trial data showed egregious misconduct by the presiding clinicians, including enrolments without informed consent; enrolments of women with medical contraindications (e.g., cancer, type 2 diabetes, obesity, hypertension); and inconsistent data collection with more than half the women lost to follow-up. The Administration declined to give its approval three times (1967, 1978 and 1983). In 1991, WHO completed a study that satisfied outstanding safety concerns and in 1992 the Food and Drug Administration approved DMPA.[193]

309. In the case of quinacrine, the controversies were transnational. Quinacrine hydrochloride pellets inserted into the vagina dissolve into liquid, burning and scarring the fallopian tubes and leading to permanent sterilization. Although major family planning organizations and government agencies, including WHO, opposed the use of quinacrine for sterilization, the procedure was performed on more than 104,410 women by 2001, through a network mobilized by two doctors. The drug lacked approved testing for long-term side effects or possible effects on foetuses. The United States ordered an end to its production and export in 1998, and the product is banned in India and Chile.[194]

310. The political mobilization of women's rights groups in response to such cases fuelled the demands for a human rights basis for health and the achievements of the International Conference in that regard, and changed the criteria on the basis of which technological and service innovations were evaluated and received investment. Numerous population and development agencies, including the WHO Special Programme of Research, Development and Research Training in Human Reproduction (now the Department of Reproductive Health Research) and UNFPA, established gender or women's advisory panels to ensure that future priorities and investments were women-centred and met more stringent criteria on side effects, user control and reversibility. WHO pursued regional "common ground" dialogues bringing women's reproductive health advocates, activists, scientists, government ministers and family planning leaders to a common table to establish collaborative agreement about family planning programme priorities. WHO also established an

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[192] A. L. Nelson, "DMPA: battered and bruised but still needed and used in the USA", *Expert Review of Obstetrics and Gynecology*, vol. 5, No. 6 (2010), pp. 673-686; K. Hawkins and J. Elliott, "Seeking approval", *Albion Monitor*, 5 May 1996; P. F. Harrison and A. Rosenfield, eds., *Contraceptive Research and Development: Looking to the Future* (Washington, D.C., National Academy Press, 1996), p. 297; Committee on Women, Population and the Environment, "Depo-Provera fact sheet", 6 January 2007; available from http://cwpe.org/node/185 (accessed 14 August 2013); T. W. Volscho, "Racism and disparities in women's use of the Depo-Provera injection in the contemporary USA", *Critical Sociology*, vol. 37, No. 5 (2011), pp. 673-688.

[193] Hawkins and Elliott, "Seeking approval".

[194] J. A. M. Scully, "Maternal mortality, population control, and the war in women's wombs: a bioethical analysis of quinacrine sterilizations", *Wisconsin International Law Journal*, vol. 19, No. 2 (2001); C. Pies, M. Potts and B. Young, "Quinacrine pellets: an examination of nonsurgical sterilization", *International Family Planning Perspectives*, vol. 20, No. 4 (1994); R. Bhatia and A. Hendrixson, "Quinacrine controversy", *Women's Health Activist Newsletter*, May/June 1999.

"introductory task force" to support a more participatory process for selecting the contraceptive method mix within countries.[195]

311. These new mechanisms for the participation of women's health advocates and other civil society organizations in family planning governance at both national and global levels ultimately reshaped research and development portfolios in notable ways, contributed to greater investment in women-centred technologies and guidelines, and further contributed to a loss of investment for technologies that were regarded as potentially risky to women's health and user control, such as the contraceptive vaccine.

2. Reproductive rights

312. The troubled history of human rights violations leading up to the International Conference on Population and Development shaped the foundational emphasis on reproductive rights in the Programme of Action.

313. Since the International Conference, countries have made progress in the promulgation and enforcement of national laws responding to the priority areas related to sexual and reproductive health and rights identified at the International Conference. Although gaps remain in access to reproductive health and in the accountability of Governments, including with respect to recourse to justice, such legal instruments serve as the basis for respecting, protecting and guaranteeing reproductive rights.

314. In the area of sexual and reproductive health and reproductive rights, less than two thirds of countries (63 per cent) have promulgated and enforced a law protecting the right to the highest attainable standard of physical and mental health, including sexual and reproductive health (Asia: 66 per cent; Oceania: 62 per cent; the Americas: 58 per cent; Africa: 55 per cent); the percentage increases to 80 per cent in Europe.

315. The vast majority of Governments allow abortion on request or to save the life of the woman and for at least one other reason such as foetal anomaly, or to safeguard the woman's health. As recognized in the key actions for further implementation of the Programme of Action, in all cases where abortion is not against the law, it must be safe (para. 63 (iii)). The World Health Organization has, however, noted that "the more restrictive legislation on abortion [is], the more likely abortion [is] to be unsafe and to result in death".[196] The fundamental human rights to life, security of the person, freedom from cruel and inhumane treatment and freedom from discrimination, among others, mean that unnecessary restrictions on abortion should be removed and that Governments should provide access to safe

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[195] "Creating common ground in the Eastern Mediterranean region: women's needs and gender perspectives in reproductive health in the Eastern Mediterranean region", report of an intercountry meeting between women's health advocates, researchers, service providers and policymakers, held at Casablanca from 10 to 13 November 1997 (World Health Organization, document WHO/FRH/WOM/98.2); "Creating common ground in Asia: women's perspectives on the selection and introduction of fertility regulation technologies", report of a meeting between women's health advocates, researchers, providers and policymakers, held at Manila from 5 to 8 October 1992 (World Health Organization, document WHO/HRP/WOM/94.1).

[196] Meeting of the Committee on Economic Social and Cultural Rights, 26 November 2010, comments by WHO (E/C.12/2010/SR.49, para. 55).

abortion services, both to safeguard the lives of women and girls and as a matter of respecting, protecting and fulfilling human rights, including the right to health.[197]

316. Globally, 73 per cent of countries have promulgated and enforced laws that ensure non-discrimination in the access to comprehensive sexual and reproductive health services, including HIV services, and a similar percentage (70 per cent) have promulgated and enforced a national law protecting the rights of people living with HIV. In the latter case, a higher proportion of countries in the Americas have done so (76 per cent) than in Africa (72 per cent), Europe (69 per cent), Asia (67 per cent) and Oceania (57 per cent).

317. Only 60 per cent of countries have promulgated and enforced a national law protecting against coercion, including forced sterilization and forced marriage; this proportion is lowest in the Americas (45 per cent).

318. If a composite indicator is computed for the dimensions of the above-mentioned five sexual and reproductive health and reproductive rights, only 32 per cent of countries have promulgated and enforced laws in all cases, although this percentage increases to 54 per cent in Europe.

319. Efforts to improve the quality and accessibility of sexual and reproductive health services since 1994 have led to significant improvements in many sexual and reproductive health indicators, with evidence of strong government actions in terms of policies, budgets and implementation measures for some of the greatest vulnerabilities; however, there has been comparatively limited progress in other areas. The following section highlights both areas of progress and continuing challenges in fulfilling sexual and reproductive health and rights.

Human rights elaborations since the International Conference on Population and Development

Box 12

Reproductive rights

Intergovernmental human rights outcomes. The Human Rights Council has recognized the critical role of sexual and reproductive health contained in the right to health. In its resolution 6/29 on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (2007), the Council encouraged the Special Rapporteur "to continue to pay attention to sexual and reproductive health as an integral element of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health".

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[197] Center for Reproductive Rights, "Whose right to life: women's rights and prenatal protections under human rights and comparative law", 2012; concluding observations of the Committee against Torture following the consideration by the Committee of the initial report of Nicaragua (CAT/C/NIC/CO/1); and report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health (A/66/254).

Other soft law. General comment No. 14 on the right to the highest attainable standard of health (2000) adopted by the Committee on Economic, Social and Cultural Rights clarifies the normative content of the right to the highest attainable standard of health: "The right to health contains both freedoms and entitlements. The freedoms include the right to control one's health and body, including sexual and reproductive freedom, and the right to be free from interference, such as the right to be free from torture, non-consensual medical treatment and experimentation". Further, general recommendation No. 24: on women and health (1999) adopted by the Committee on the Elimination of Discrimination against Women elaborates measures that should be taken to ensure equality for all women in the implementation of the right to health, "affirming that access to health care, including reproductive health, is a basic right under the Convention on the Elimination of All Forms of Discrimination against Women".

D. Sexual and reproductive health and rights and lifelong health for young people

320. The largest generation of adolescents in history is now entering sexual and reproductive life. Their access to sexual and reproductive health information, education, care, and family planning services and commodities is essential to achieving the goals set out in the Programme of Action. The Programme of Action requires that countries ensure that health-care providers do not restrict the access of adolescents to services and information, and that "these services must safeguard the rights of adolescents to privacy, confidentiality, respect and informed consent, respecting cultural values and religious beliefs" (para. 7.45). **States should review all such policies and remove legal, regulatory and social barriers to reproductive health information and care for adolescents.**

321. Pregnancy has major consequences for a girl's health. About 70,000 adolescents in developing countries die annually of causes related to pregnancy and childbirth. Nine of 10 births to girls below age 18 occur within early marriage. Researchers have found that girls who become pregnant before age 15 in low- and middle-income countries have double the risk of maternal death and obstetric fistula than older women (including older adolescents), in particular in sub-Saharan Africa and South Asia. There are also significant health risks to the infants and children of adolescent mothers: stillbirths and newborn deaths are 50 per cent higher among infants of adolescent mothers than among infants of mothers between the ages of 20 and 29. About 1 million children born to adolescent mothers do not make it to their first birthday.[198]

322. The extent to which young people have access to quality services is not well documented, but their poor health outcomes point to significant gaps in coverage, for example, 8.7 million abortions undergone by adolescent girls and young women aged

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[198] *State of World Population, Motherhood in Childhood* (see footnote 98 above).

15-24 years in 2008[199] and high rates of sexually transmitted infections, including HIV. A 2012 review of available international data on sexual and reproductive health of young people (up to age 24), underscored these numerous gaps.[200] The operational review also emphasized the paucity of comparable data on adolescent health, even in the areas with the greatest policy focus (such as HIV infection and maternal mortality).[201]

323. Based on the available evidence, the poorest adolescent health profiles are in sub-Saharan Africa, including the highest rates of mortality from both maternity-related and infectious causes; the mortality rate is higher for females than males (see figure 20). There is a greater than seventy-fold variation in maternal mortality rates between countries in the region, with the highest rates among 15- to 19-year-olds in Chad and the lowest in South Africa.[202] Deaths due to injury become increasingly significant with age (that is, comparing the age groups 10-14, 15-19 and 20-24 years), and by ages 15-19 injuries account for more than 50 per cent of deaths among males in the Americas and close to 50 per cent of deaths in all other regions (e.g., Europe, the Eastern Mediterranean, South-East Asia and the Western Pacific), except for Africa.

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[199] Shah and Ahman, "Unsafe abortion differentials in 2008 by age and developing country region" (see footnote 15 above).

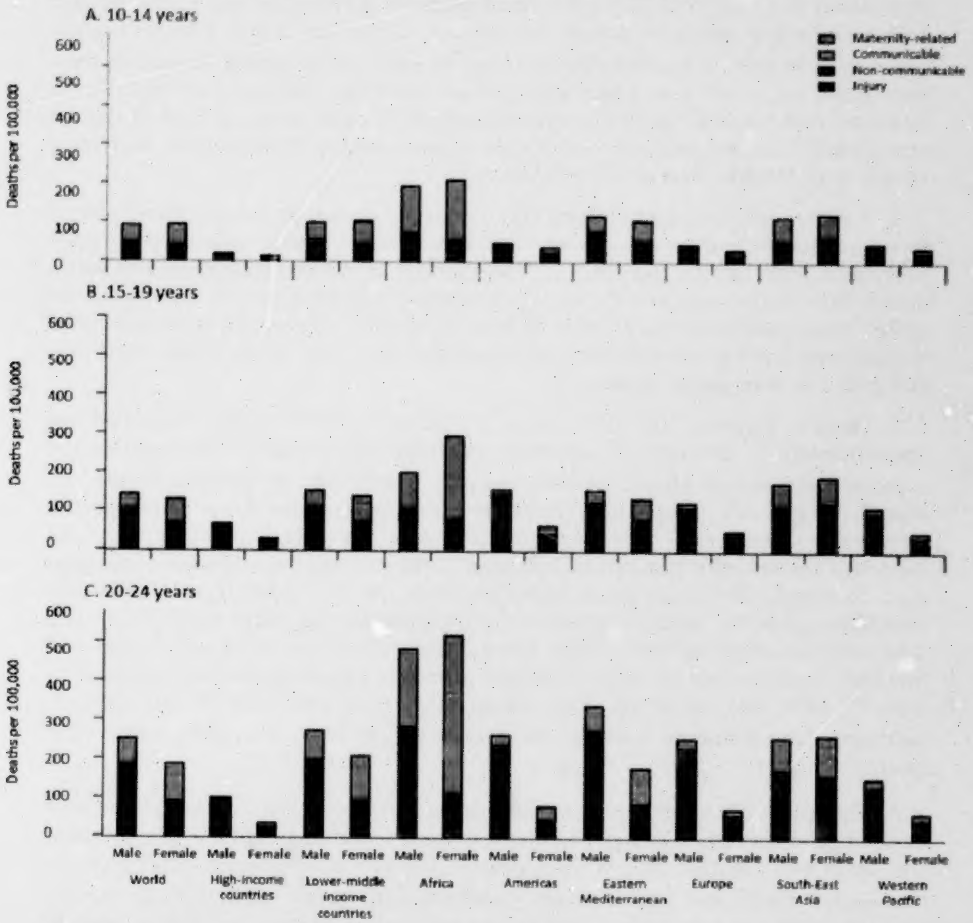
[200] G. C. Patton and others, "Health of the world's adolescents: a synthesis of internationally comparable data", *The Lancet*, vol. 379, No. 9826 (28 April 2012), pp. 1665-1675.

[201] Ibid., p. 1665.

[202] Ibid., p. 1667.

Figure 20

Mortality (per 100,000) among young people from maternity-related causes, communicable and non-communicable diseases and injury



A. 10-14 years

B. 15-19 years

C. 20-24 years

Source: G. C. Patton and others, "Global patterns of mortality in young people: a systematic analysis of population health data", *The Lancet*, vol. 374, No. 9693 (12 September 2009), p. 885.

324. For females, adolescence and young adulthood are accompanied by acute needs for sexual and reproductive health services. Early childbirth (before age 18) is closely correlated with early marriage. The country with the highest rate of early marriage (before age 18) is Niger, with 75 per cent; rates are high throughout sub-Saharan Africa. Bangladesh has the highest rate in Southern Asia, with 66 per cent.[203] Sixteen million adolescent girls aged 15-19 years and 2 million girls under 15 years give birth every year.[204]

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[203] Ibid., p. 1670.

[204] WHO, "Adolescent pregnancy", Factsheet No. 364 (May 2012).

325. Girls under age 15 are five times more likely to die from maternity-related causes than women over age 20, and pregnancy and childbirth are the leading cause of death for women of childbearing age in Africa and South Asia.[205]

326. From 2001 to 2012 HIV prevalence declined globally among young people, both females and males.[206] Across sub-Saharan Africa, the region with the highest prevalence of HIV, prevalence declined by 42 per cent. Dramatic decreases have been noted across all low- and middle-income countries. Variations are significant, however, with increases in HIV prevalence noted for male youths in Eastern Europe and Central Asia, and increases noted for both male and, in lesser proportion, female youths in the Middle East and North Africa.[206]

327. Furthermore, in regions where HIV is endemic, such as Africa, where almost three quarters of all people living with HIV reside, female youth have higher prevalence rates of HIV than males,[206] particularly at the youngest ages, and males do not have comparable prevalence levels in many African countries until age 30 or more. These patterns are reversed in regions where HIV is predominantly transmitted through men having sex with men or intravenous drug use, where young males are at higher risk than young females.[206]

328. Despite progress, in 2009 young people aged 15-24 years accounted for approximately 41 per cent of new HIV infections worldwide,[207] highlighting the urgency for renewed efforts towards ensuring availability of targeted sexual and reproductive health information, education and services that keep young people informed of their risks and provide them access to condoms, screening and treatment for sexually transmitted infections, and HIV testing and care. Regarding data coverage, 29 countries, representing only 29 per cent of the adolescent population globally, collect data on HIV prevalence among youth aged 15-24, with data collected predominantly from sub-Saharan Africa and parts of Central and Southern Asia, and a selection of wealthy countries with comparatively lower HIV rates.[208] HIV data on young adolescents aged 10-14 years old is very limited, hindering advancements towards the prevention of new infections within this group.[209]

329. The 2013 UNAIDS report on the global AIDS epidemic also reported that there are limited data on rates of comprehensive knowledge of HIV transmission, with data available for only 35 per cent of the global adolescent population.[210] Knowledge levels are low in many countries with generalized HIV epidemics, generally falling below 50 per cent of the national adolescent population, and no country exhibited comprehensive HIV knowledge among more than 65 per cent of their adolescent population. Significantly, females in sub-Saharan African countries

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[205] UNFPA, "Giving birth should not be a matter of life and death" (see footnote 14 above).

[206] UNAIDS, *Global Report: UNAIDS Report on the Global AIDS Epidemic 2013*, pp. 16-17 (see footnote 16 above).

[207] Unpublished estimates from *Global Report: UNAIDS Report on the Global AIDS Epidemic 2010*, cited in UNAIDS, *Securing the Future Today: Synthesis of Strategic Information on HIV and Young People* (Geneva, 2011).

[208] Patton and others, "Health of the world's adolescents: a synthesis of internationally comparable data", p. 1667.

[209] UNAIDS, *Global Report: UNAIDS Report on the Global AIDS Epidemic 2013*, p. 18.

[210] Ibid.; Patton and others, "Health of the world's adolescents: a synthesis of internationally comparable data", p. 1671.

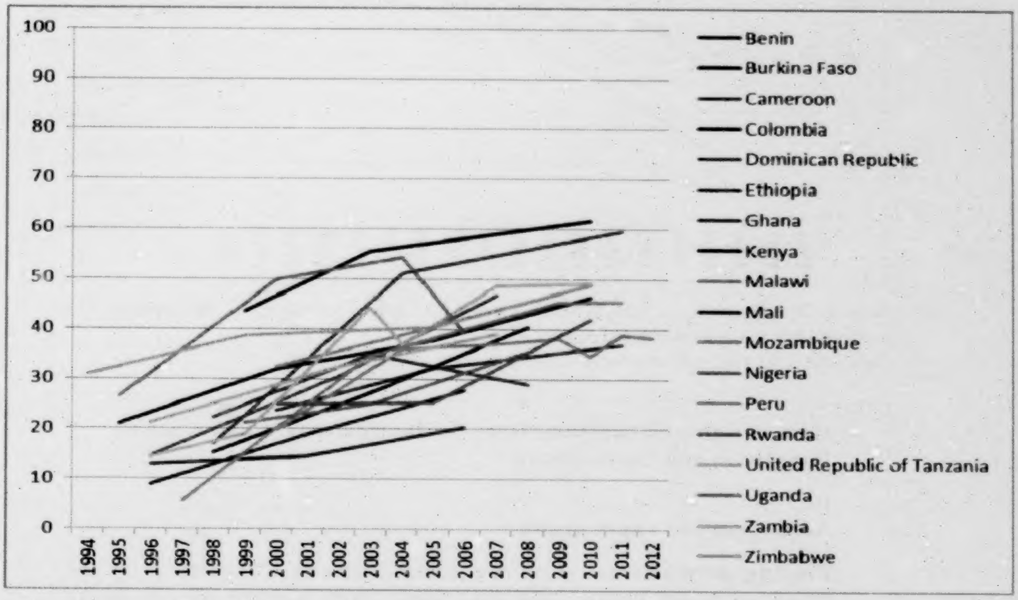
had lower knowledge levels than males, which is alarming considering the high risk of HIV among young women.

330. Demographic and Health Surveys data from countries with at least three surveys since 1994 show that condom use at last sex among young men and women aged 15-24 has been on the rise in most countries since 1994; however, condom use by females overall has been consistently lower than condom use by males (see figures 21 and 22). Self-reported condom use can vary by sex owing to sex differentials in multiple partnerships and to tendencies to report desirable behaviours, that is, social desirability bias. These trends in condom use are most likely contributing to the declining HIV incidence among young people 15-24 years that has been observed over the last decade.

Figure 21

Trends in the percentage of never married women aged 15-24 using a condom at last sex

(Countries with at least 3 demographic and health surveys or AIDS indicators survey since 1994)



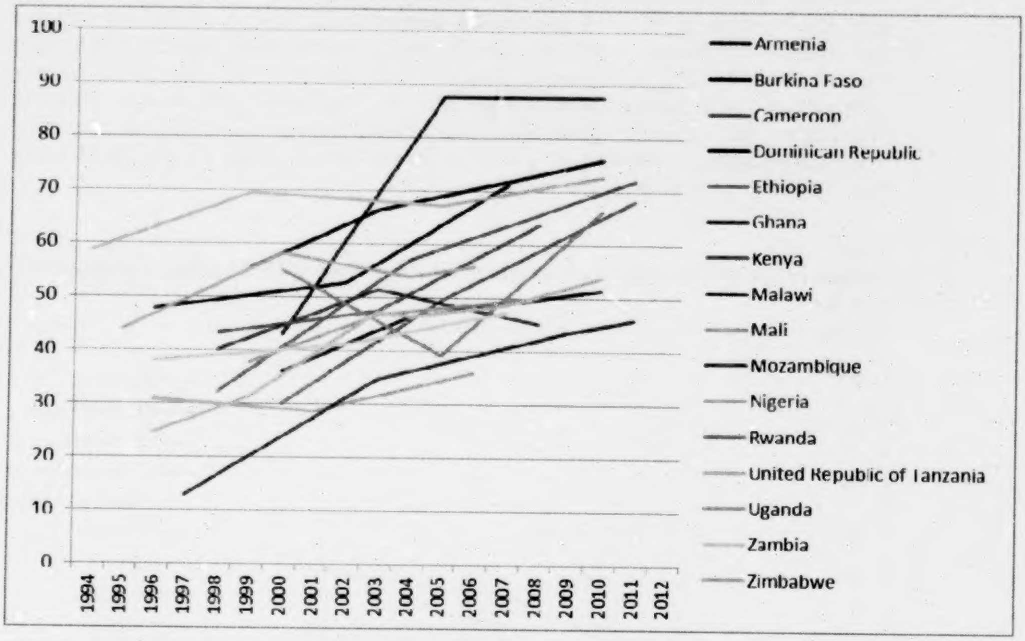
Source: Demographic and Health Surveys and AIDS indicators survey on 28 October 2013, available from www.measuredhs.com.

Note: All countries with available data for at least two time points.

Figure 22

Trends in the percentage of never married young men aged 15-24 using a condom at last sex

(Countries with at least three demographic and health surveys or AIDS indicators surveys since 1994)



Source: Demographic and Health Surveys and AIDS indicators survey on 28 October 2013, available from www.measuredhs.com.

Note: All countries with available data for at least two time points.

Human rights elaborations since the International Conference on Population and Development

Box 13

Adolescent and youth health

Binding instruments. Both the Ibero-American Convention on the Rights of Youth (2005; entry into force 2008) and the African Youth Charter (2006; entry into force 2009) contain articles elaborating the right to health for youth. The African Youth Charter encourages youth participation in health, obliging States to "[s]ecure the full involvement of youth in identifying their reproductive and health needs". The Charter requires States to "provide access to youth-friendly reproductive health services including contraceptives, antenatal and post-natal services", to "[i]nstitute comprehensive programmes … to prevent unsafe abortion" and to "[t]ake steps to provide equal access to health care services and nutrition for girls and young women". The Charter also devotes specific attention to HIV and AIDS, obliging States to institute programmes to address the HIV and AIDS pandemic, including to "[e]xpand the availability and encourage the uptake of voluntary counselling and confidential testing for HIV/AIDS" and to "[p]rovide timely access to treatment for young people infected with HIV/AIDS". The Ibero-American Convention on the Rights of Youth recognizes "the right of youth to comprehensive, high-quality health", including "specialized health care ... and promotion of sexual and reproductive health".

Other soft law. Through general comments and recommendations, human rights treaty bodies have recognized the evolving capacities of adolescents to make decisions about their sexual and reproductive health, and have urged States to develop programmes to provide such services to adolescents.[211] General comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (2013) adopted by the Committee on the Rights of the Child clarifies the normative content of the right of children and adolescents to the enjoyment of the highest attainable standard of health, including health-care services, as well as the binding obligations of States party to the Convention to respect, protect, promote and fulfil the rights of the child to health. States are urged to ensure access to sexuality education and information, not limiting access on the basis of third-party consent (that is, parental or health authority),[212] and to eliminate laws that act as barriers to accessing sexual and reproductive health services.[213] Treaty bodies have also emphasized that all young people should have access to confidential and child-sensitive services,[214] and adolescents who become pregnant should be able to remain in, and return to, school.[215]

1. Targeted youth programmes

331. Failures to recognize, prioritize and invest in adolescents and their sexual and reproductive health have fatal consequences: high rates of HIV that can lead to early death; unplanned and unwanted early pregnancies, with exacerbated risks for maternal mortality and morbidity, such as obstetric fistula; and higher rates of infant

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[211] Committee on the Rights of the Child, general comment No. 4 (2003) on adolescent health and development in the context of the Convention on the Rights of the Child (see A/59/41, annex X), paras. 1 and 31).

[212] Committee on the Elimination of Discrimination against Women, general recommendation 24 concerning article 12 of the Convention on the Elimination of All Forms of Discrimination against Women on women and health, adopted by the Committee at its twentieth session (see A/54/38/Rev.1, part one, chap. I, sect. A).

[213] See for example the concluding observations of the Committee on Economic, Social and Cultural Rights following the consideration by the Committee of the combined second to fourth periodic report of Peru (E/C.12/PER/CO/2-4, para. 21).

[214] See concluding observations of the Committee on the Rights of the Child following the consideration by the Committee of the second periodic report of Oman (CRC/C/OMN/CO/2); and of the second periodic report of Paraguay (CRC/C/15/Add.166, para. 42).

[215] See for example the concluding observations of the Committee on the Rights of the Child following the consideration by the Committee of the second periodic report of Senegal (CRC/C/SEN/CO/2, paras. 54-55).

and child mortality.[216] Furthermore, adolescents have limited life and work skills to care for their children, and are often forced by schools or their circumstances to abandon their schooling. Therefore, early parenthood can enhance the risk of poverty.[217] The need for greater investments in youth-friendly sexual and reproductive education and health services tailored to adolescents is critical. Young people may be afraid of, or deterred by, intimidating environments, including inflexible opening hours, cost of services, resistant or unresponsive health-care providers and long distances to clinics, or be uncomfortable about requesting assistance or resources; they may also be unaware of what services are offered.[218]

332. Globally, the number of adolescent sexual and reproductive health programmes documented in the literature is substantial, with varied designs, but there are comparatively few at national scale or with reliable periodic evaluation.[219] While programmes may benefit from local tailoring, far greater attention should be given to systematic interventions and evaluation of impact.

333. In 2006, WHO conducted a retrospective study of 16 interventions aimed at increasing young people's use of health services and their effectiveness.[220] It evaluated these interventions against the explicit targets set by the General Assembly in its resolution S-26/2, adopted at its special session on HIV and AIDS in 2001, including that 90 per cent of young people aged 15-24 years should have access to the necessary services to decrease their vulnerability to HIV by 2005, and 95 per cent by 2010.[221]

334. The review concluded that there was sufficient evidence of the effectiveness of components of these interventions to recommend the wide implementation of interventions that included training for service providers, improvements for clinics

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[216] E. Loaiza and M. Liang, *Adolescent Pregnancy: A Review of the Evidence* (New York, United Nations Population Fund, 2013); Save the Children, *State of the World's Mothers 2004: Children Having Children* (2004); WHO, *Adolescent Pregnancy: Issues in Adolescent Health and Development*, WHO Discussion Papers on Adolescence (Geneva, 2004); UNFPA, *UNFPA Framework for Action on Adolescents and Youth: Opening Doors with Young People — 4 Keys* (New York, 2007), p. 21.

[217] *State of World Population 2013: Motherhood in Childhood*, pp. iv-vi and 17-31.

[218] V. Chandra-Mouli, P. and J. Feguson, "The World Health Organization's work on adolescent sexual and reproductive health", Bundesgesundheitsblatt — Gesundheitsforschung — Gesundheitsschutz, vol. 56, No. 2 (February 2013), pp. 256-261; UNFPA, *UNFPA Strategy on Adolescents and Youth: Towards Realizing the Full Potential of Adolescents and Youth* (New York, 2013); WHO, *Making Health Services Adolescent Friendly: Developing National Quality Standards for Adolescent-Friendly Health Services* (Geneva, 2012); Guttmacher Institute and International Planned Parenthood Federation (IPPF), "Facts on the sexual and reproductive health of adolescent women in the developing world", April 2010, available from http://www.guttmacher.org/pubs/FB-Adolescents-SRH.pdf; UNFPA, *Framework for Action on Adolescents and Youth: Opening Doors with Young People — 4 Keys*; A. Tylee and others, "Youth-friendly primary care services: how are we doing and what more needs to be done?", *The Lancet*, vol. 369, No. 9572 (2007).

[219] N. Haberland and D. Rogow, "Comprehensive sexuality education", background paper prepared for an expert group meeting on adolescent sexual and reproductive health, held at Greentree, New York, in February 2013.

[220] B. Dick and others, "Review of the evidence for interventions to increase young people's use of health services in developing countries", in *Preventing HIV/AIDS in Young People: A Systematic Review of the Evidence from Developing Countries*, D. A. Ross, B. Dick and J. Ferguson, eds., WHO Technical Report Series No. 938 (Geneva, World Health Organization, 2006), pp. 151-204.

[221] Ibid., p. 152.

so that they would be more youth-friendly, and community-based activities to generate demand, with careful monitoring of quality, impact and coverage of sexual and reproductive health services.[222]

335. The WHO review acknowledged that while the use of health services had increased as a result of these interventions, the evidence used to assess impact was generally weak or mixed; that reporting lacked detailed descriptions in some cases; and that there were difficulties interpreting data, thereby limiting conclusions or recommendations. The review therefore called for more rigorous research and evaluation, particularly to determine the effectiveness of involvement of other sectors in interventions.[223]

336. A 2007 global assessment of youth-friendly primary care services that examined the benefits and effectiveness of accessing youth-friendly health services and facilities on health outcomes drew further conclusions about the need for stronger research and evaluation. The well-documented barriers faced by young people in accessing services had not been addressed in a comprehensive way, and the evidence for the effectiveness of youth-friendly initiatives was inadequately measured against young peoples' health outcomes. Although utilization had often increased, there was little clear evidence that making services youth-friendly, and securing the investments required to do so, improved health outcomes. The study called for systematic and well-designed interventions with regular assessments, and for interventions to incorporate targets and principles into their design and to assess their strategies against these targets, including those listed in the WHO framework for development of youth-friendly services.[224]

337. **States should fund and develop, in partnership with young people and health-care providers, policies, laws and programmes that recognize, promote and protect young peoples' sexual and reproductive health and rights and lifelong health. All programmes serving adolescents and youth, whether in or out of school, should provide referral to reliable, quality sexual and reproductive health counselling and services.**

338. **States should remove legal, regulatory and policy barriers to sexual and reproductive health services for adolescents and youth, and ensure information and access to contraceptive technologies; prevention, diagnosis and treatment for sexually transmitted infections and HIV, including the HPV vaccine; and referrals to services dealing with other health concerns such as mental health problems.**

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[222] WHO and Pathfinder International, *Evolution of the National Adolescent-Friendly Clinic Initiative in South Africa*, Analytic Case Studies: Initiatives to Increase the Use of Health Services by Adolescents (Geneva, World Health Organization, 2009), pp. 6-7; Dick and others, "Review of the evidence for interventions to increase young people's use of health services in developing countries". In 2009, at the request of policymakers and programme managers in countries, WHO published the detailed findings of the evaluation in its series Analytic Case Studies: Initiatives to Increase the Use of Health Services by Adolescents, to assist Governments and non-governmental organizations to implement and scale up quality adolescent-friendly health services, and to assist health workers with necessary technical and financial support.

[223] Dick and others, "Review of the evidence for interventions to increase young people's use of health services in developing countries".

[224] Tylee and others, "Youth-friendly primary-care services: how are we doing and what more needs to be done?"

2. Comprehensive sexuality education

339. The Programme of Action called on Governments to provide sexuality education to adolescents and to ensure that such programmes addressed specific topics, among them gender relations and equality, violence against adolescents, responsible sexual behaviour, contraception, family life, and sexually transmitted infections, HIV and AIDS prevention (paras. 4.29, 7.37, 7.41 and 7.47).[225]

(a) Recent findings from comprehensive sexuality education evaluations

340. Numerous reviews of sexuality education evaluation studies have been conducted since 1994. These evaluations were of community-based and school-based programmes in both developing and developed countries. The evidence from these reviews points to several findings and lessons:

(a) Comprehensive sexual risk reduction interventions do not lead to earlier sexual initiation or greater sexual frequency;[226]

(b) Most sexuality education programmes demonstrate increased knowledge, and about two thirds of them demonstrate some positive impacts on behaviour;[227]

(c) Among comprehensive sexuality education programmes that track health outcomes to measure impact, there is little measurable effect on rates of HIV, sexually transmitted infections and unintended pregnancy;

(d) Efforts to link programme results with specific programme characteristics have been inconsistent or lacked consensus.[228]

However, several reviews identified elements related to teaching methods: effective programmes tend to incorporate skills building, especially condom-use skills, and interactive activities help students personalize information.[229]

341. Reviewers recommended the use of biological health outcomes as a more reliable, objective measure of programme efficacy than self-reported sexual

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[225] See also Commission on Population and Development resolution 2011/1 (E/2011/25, chap. I.B).

[226] S. M. Napierala Mavedzenge, A. M. Goyle and D. A. Ross, "HIV prevention in young people in sub-Saharan Africa: a systematic review", *Journal of Adolescent Health*, vol. 49, No. 6 (2011), pp. 568-586; D. Kirby, *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases* (Washington, D.C., National Campaign to Prevent Teen Pregnancy, 2007); K. Michielsen and others, "Effectiveness of HIV prevention for youth in sub-Saharan Africa: a systematic review and meta-analysis of randomized and nonrandomized trials", *AIDS*, vol. 24, No. 8 (2012), pp. 1193-1202; H. B. Chin and others, "The effectiveness of group-based comprehensive risk-reduction and abstinence education interventions to prevent or reduce the risk of adolescent pregnancy, human immunodeficiency virus, and sexually transmitted infections: two systematic reviews for the guide to community preventive services", *American Journal of Preventive Medicine*, vol. 42, No. 3 (2012), pp. 272-294.

[227] Kirby, *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*.

[228] Ibid., Napierala Mavedzenge, Goyle and Ross, "HIV prevention in young people in sub-Saharan Africa: a systematic review"; M. Jukes, S. Simmons and D. Bundy, "Education and vulnerability: the role of schools in protecting young women and girls from HIV in southern Africa", *AIDS*, vol. 22, No. 4 (2008), pp. S41-S56.

[229] V. A. Paul-Ebhohimhen, A. Poobalan and E. R. van Teijlingen, "A systematic review of school-based sexual health interventions to prevent STI/HIV in sub-Saharan Africa", *BMC Public Health*, vol. 8, No. 4 (2008).

behaviour.[230] One recent review that considered only studies that utilized health outcomes as a measure of impact found that comprehensive sexuality education curricula that emphasized gender and power were markedly more likely to reduce rates of sexually transmitted infections and/or unintended pregnancy than "gender-blind" curricula.[231] This finding resonates with other evidence on the value of addressing gender norms and relationship dynamics within comprehensive sexuality education. For example, studies have found that women and men with more equitable gender attitudes are significantly more likely to use contraception and/or condoms[232] and significantly more likely to receive pre-natal care and to deliver in a maternity facility.[233] In five high-fertility countries in East Africa, men who support gender inequality had higher fertility aspirations, independent of education, income, or religion.[234]

342. Relationship skills are necessary for many young people, as not all children have had the mentoring to treat others with dignity, respect and non-discrimination; schools can provide values-based learning that will enhance human relationships. **States should guarantee for boys, girls, adolescents and young people the opportunities, mentoring and skills to build healthy social relationships, harmonious coexistence and a life free from violence through multisectoral strategies and education that engage peer groups and families, and promote tolerance and appreciation of diversity, gender equality, self-respect, conflict resolution and peace.**

343. **National leaders at the highest level, community leaders, faith-based institutions and other thought leaders are called upon to develop, creatively and publicly and in collaboration with young people, media and communications that address the negative social consequences of gender stereotypes, promote the values and practice of gender equality and honour non-violent masculinities.**

344. A 2012 review of curricula in 10 East and Southern African countries suggested that critical thinking about gender and rights was not yet sufficiently implemented within comprehensive sexuality and HIV education.[235]

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[230] Napierala Mavedzenge, Goyle and Ross, "HIV prevention in young people in sub-Saharan Africa: a systematic review"; Kirby, *Emerging Answers 2007: Research Findings on Programs to Reduce Teen Pregnancy and Sexually Transmitted Diseases*; Michielsen and others, "Effectiveness of HIV prevention for youth in sub-Saharan Africa: a systematic review and meta-analysis of randomized and nonrandomized trials"; A. Harrison and others, "HIV prevention for South African youth: which interventions work? A systematic review of current evidence", *BMC Public Health*, vol. 10 (February 2010).

[231] Haberland and Rogow, "Comprehensive sexuality education".

[232] A. M. Karim and others, "Reproductive health risk and protective factors among unmarried youth in Ghana", *International Family Planning Perspectives*, vol. 29, No. 1 (2003), pp. 14-24; R. Stephenson, D. Bartel and M. Rubardt, "Constructs of power and equity and their association with contraceptive use among men and women in rural Ethiopia and Kenya", *Global Public Health*, vol. 7, No. 6 (2012), pp. 618-634.

[233] Y. Cui and others, "Effect of married women's beliefs about gender equity on their use of prenatal and delivery care in rural China", *International Journal of Gynecology and Obstetrics*, vol. 111, No. 2 (2010), pp. 148-151.

[234] R. Snow, R. A. Winter and S. D. Harlow, "Gender attitudes and fertility aspirations among young men in five high fertility East African countries", *Studies in Family Planning*, vol. 44, No. 1 (2013), pp. 1-24.

[235] Population Council, *Sexuality Education: A Ten-Country Review of School Curricula in East and Southern Africa* (Paris, United Nations Educational, Scientific and Cultural Organization; New York, United Nations Population Fund, 2012).

345. Support by Governments for youth sexual and reproductive health services in the global survey varied starkly. Only 54 per cent of countries in Africa addressed the issue of ensuring access by adolescents and youth to sexual and reproductive health information and services that warrant and respect privacy, confidentiality and informed consent, compared with 96 per cent, 90 per cent and 80 per cent of countries in the Americas, Europe and Asia respectively.

346. As the evidence builds for a paradigm shift towards programmes that emphasize critical thinking about gender and power, a question arises about the extent to which this is being implemented. In the global survey 70 per cent of Governments reported that the issue of "revising the contents of curricula to make them more gender-sensitive" was being addressed, but the implications or thoroughness of that effort was not questioned. The regional reviews and outcomes stressed the importance of designing and implementing effective, comprehensive sexuality education that addresses the key elements linking the five thematic pillars of the operational review.

347. **States should recognize that comprehensive sexuality education, consistent with the evolving capacities of young people both in and out of school, is essential to enable them to protect themselves from unwanted pregnancy, HIV and sexually transmitted infections; to promote values of tolerance, mutual respect and non-violence in relationships; and to plan their lives. States should design and implement comprehensive sexuality education programmes that provide accurate information, taking into account scientific data and evidence about human sexuality, including growth and development, anatomy and physiology; reproduction, pregnancy and childbirth; contraception; HIV and sexually transmitted infections; family life and interpersonal relationships; culture and sexuality; human rights protection, fulfilment and empowerment; non-discrimination, equality and gender roles; sexual behaviour; sexual abuse, gender-based violence and harmful practices; as well as youth-friendly programmes to explore values, attitudes and norms concerning sexual and social relationships; promote the acquisition of skills and encourage young people to assume responsibility for their own behaviour and to respect the rights of others; are gender-sensitive and life-skills-based; and provide young people with the knowledge, skills and efficacy to make informed decisions about their sexuality.**

Human rights elaborations since the International Conference on Population and Development

Box 14

Comprehensive sexuality education

Binding instruments. The Ibero-American Convention on the Rights of Youth (2005; entry into force 2008) recognizes that "the right to education also includes the right to sexual education" and that "[s]exual education shall be taught at all educational levels".

Other soft law. Human rights treaty bodies have recognized that the right to health includes "underlying determinants of health, such as ... access to health-related education and information, including on sexual and reproductive health", as well as the right to seek, receive and disseminate health information.[236] Treaty monitoring bodies have also highlighted that States should ensure that all adolescents have access to information on sexual and reproductive health, both in school and in other settings for adolescents who are not in school.[237]

3. Fertility, contraception and family planning

348. Globally, fertility fell by 23 per cent between 1990 and 2010.[238] Falling fertility is largely the result of a desire for smaller families, coupled with better access to contraception. Aspirations for smaller families are affected by many factors, including improvements in child survival and expanded opportunities for women, especially education. In Africa as a whole, and sub-Saharan Africa in particular, fertility has fallen more slowly than in other regions, and remains higher than in any other region in the world.[239]

349. Globally, contraceptive prevalence among women aged 15 to 49 who are married or in union and currently using any method of contraception rose from 58.4 per cent in 1994 to 63.6 per cent in 2012, a rise of approximately 10 per cent.[240] While contraceptive use increased faster (from 40 to 54 per cent) over that

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[236] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) on the right to the highest attainable standard of physical and mental of health (article 12 of the International Covenant on Economic, Social and Cultural Rights) (E/2001/22, annex IV), paras. 11 and 12 (b) (iv).

[237] Committee on the Rights of the Child, general comment No. 4 (2003) on adolescent health and development in the context of the Convention on the Rights of the Child (see A/59/41, annex X), paras. 26 and 28); concluding observations of the Committee on the Rights of the Child following the consideration by the Committee of the fourth periodic report of Australia (CRC/C/AUS/CO/4, para. 67); concluding observations of the Committee on Economic, Social and Cultural Rights following the consideration by the Committee of the fifth periodic report of the Russian Federation (E/C.12/RUS/CO/5, para. 30); Committee on the Elimination of Discrimination against Women, general recommendation 24, concerning article 12 of the Convention on the Elimination of All Forms of Discrimination against Women on women and health, adopted by the Committee at its twentieth session (see A/54/38/Rev.1, part one, chap. I, sect. A, para. 23); concluding observations of the Committee on the Elimination of Discrimination against Women following the consideration by the Committee of the combined initial and second periodic report of Turkmenistan (CEDAW/C/TKM/CO/2, paras. 30-31); concluding observations of the Committee on the Rights of the Child following the consideration by the Committee of the second periodic report of Uruguay (CRC/C/URY/CO/2, para. 52); concluding observations of the Committee on Economic, Social and Cultural Rights following the consideration by the Committee of the combined fourth and fifth periodic report of the Netherlands (E/C.12/NDL/CO/4-5, para. 27).

[238] The decrease in the global total fertility rate is calculated using the point estimates for the years 1990 and 2010 from *World Population Prospects: The 2012 Revision* (ST/ESA/SER.A/336).

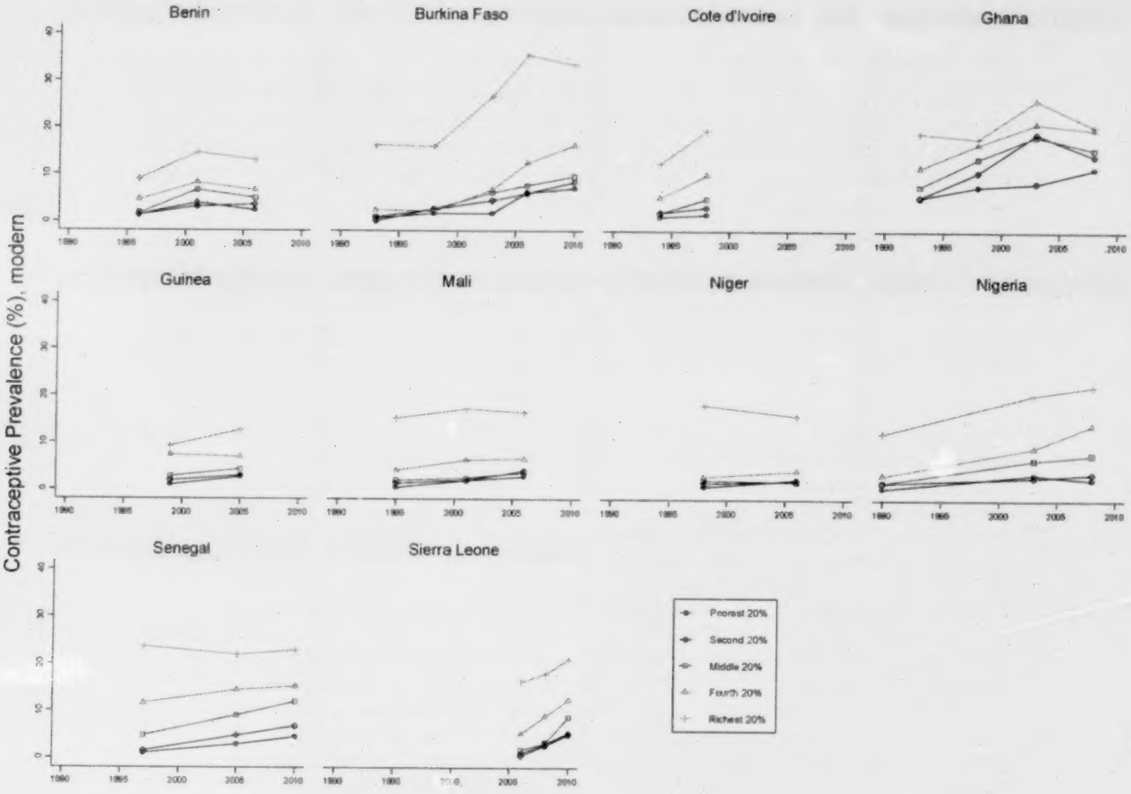
[239] J. G. Cleland, R. P. Ndugwa and E. M. Zulu, "Family planning in sub-Saharan Africa: progress or stagnation?", *Bulletin of the World Health Organization*, vol. 89, No. 2011 (2010), pp. 137-143.

[240] United Nations, Department of Economic and Social Affairs, Population Division, *World Contraceptive Use 2012* (POP/DB/CP/Rev2012); available from www.unpopulation.org.

period in developing countries (excluding China), use in developing countries remained much lower than in developed countries, where nearly 72 per cent of married or in-union women used contraception. Contraceptive prevalence increased more rapidly in the 1990s than in the 2000s, and in a number of extremely poor countries, prevalence has remained below 10 per cent.[241]

Figure 23

Trends in modern contraceptive prevalence rate in Northern and Western Africa, by household wealth quintile



Source: Demographic and Health Surveys, available from www.measuredhs.com (accessed 15 June 2013); multiple indicator cluster surveys, available from www.unicef.org/statistics/index_24302.html (accessed on 15 June 2013), all countries with available data for at least two time points.

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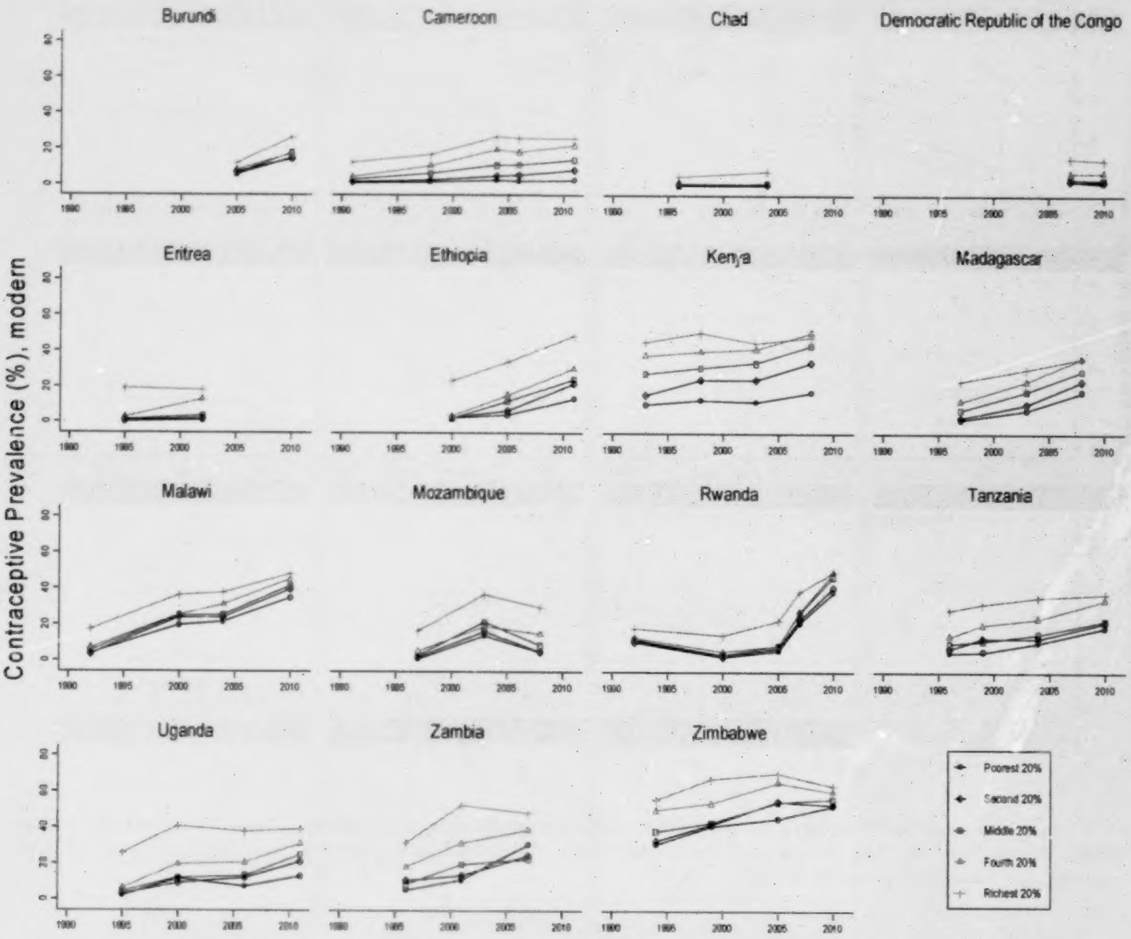
[241] N. Ortayli and S. Malarcher, "Equity analysis: identifying who benefits from family planning programs", *Studies in Family Planning*, vol. 41, No. 2 (2010), pp. 101-108; L. Alkema and others, "National, regional, and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015: a systematic and comprehensive analysis", *The Lancet*, vol. 381, No. 9878 (2013), pp. 1642-1652.

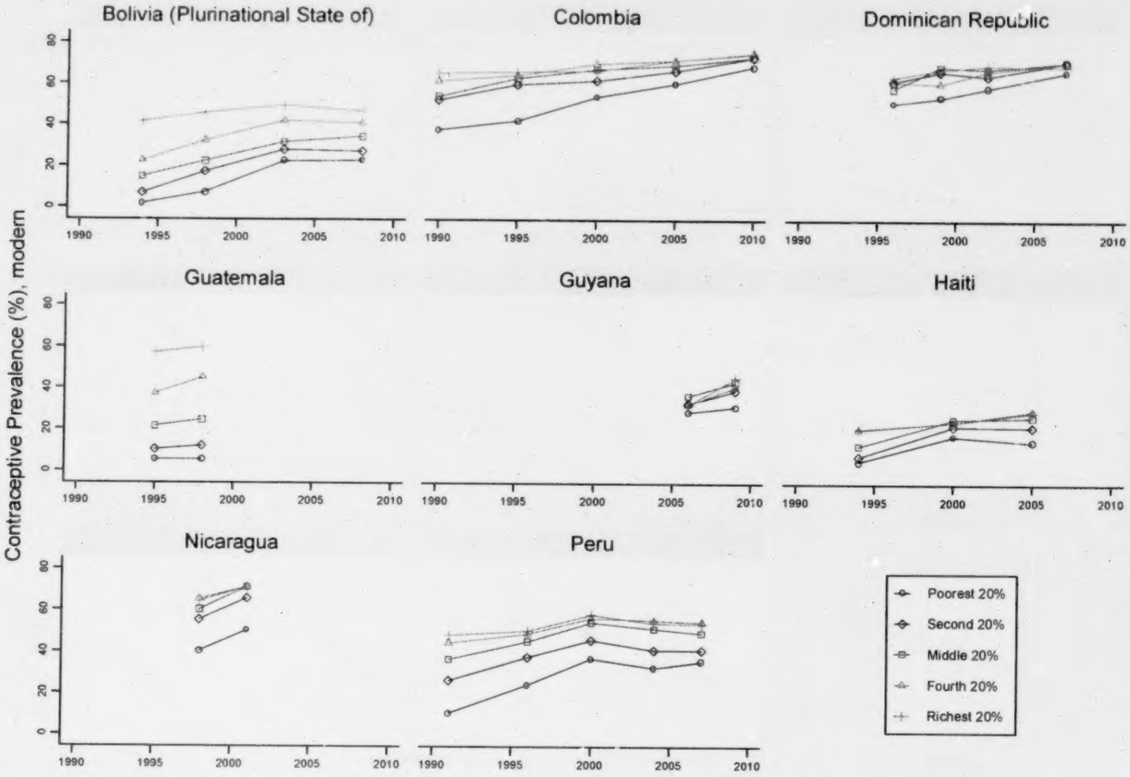
Figure 24
Trends in modern contraceptive prevalence rate in Eastern, Middle and Southern Africa, by household wealth quintile



Source: Demographic and Health Surveys, available from www.measuredhs.com (accessed on 15 June 2013); multiple indicator cluster surveys, available from www.unicef.org/statistics/index_24302.html (accessed on 15 June 2013), all countries with available data for at least two time points.

Figure 25

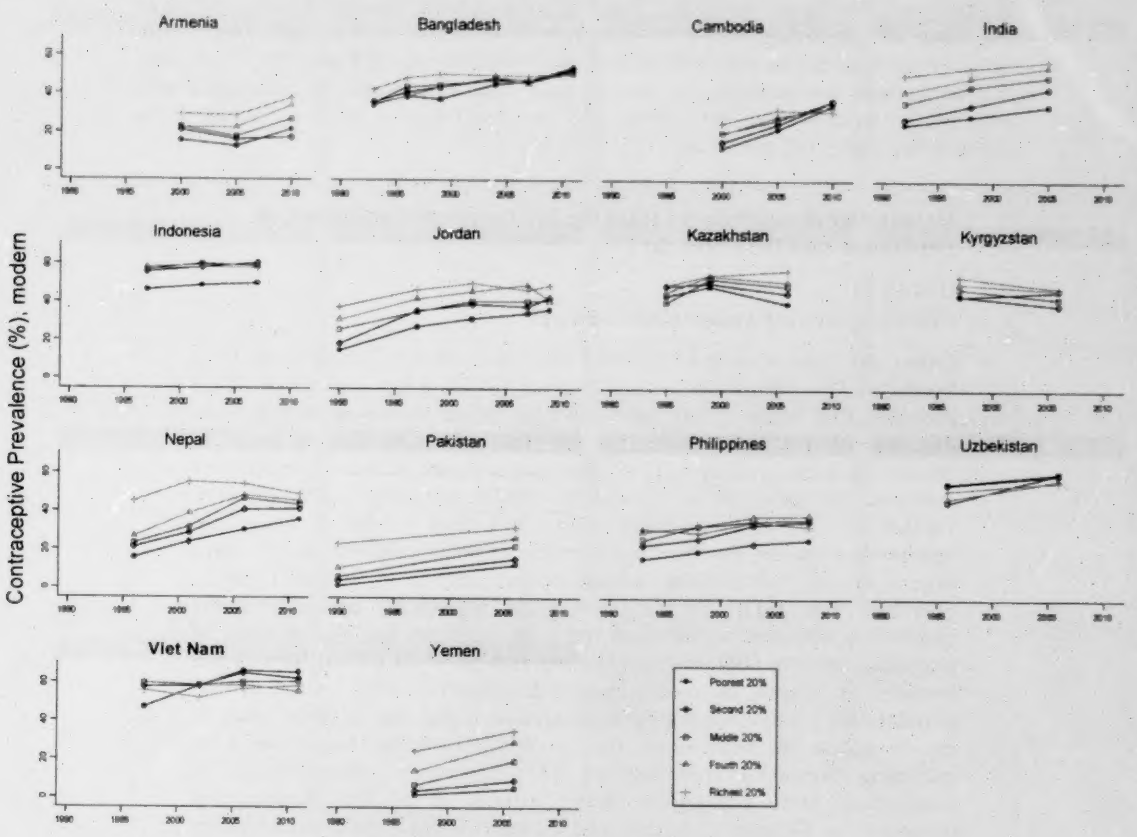
Trends in modern contraceptive prevalence rate in the Americas, by household wealth quintile



Source: Demographic and Health Surveys, available from www.measuredhs.com (accessed on 15 June 2013); multiple indicator cluster surveys, available from www.unicef.org/statistics/index_24302.html (accessed on 15 June 2013), all countries with available data for at least two time points.

Figure 26

Trends in modern contraceptive prevalence rate in Asia, by household wealth quintile



Source: Demographic and Health Surveys, available from www.measuredhs.com (accessed on 15 June 2013); multiple indicator cluster surveys, available from www.unicef.org/statistics/index_24302.html (accessed on 15 June 2013), all countries with available data for at least two time points.

350. Global unmet need for modern contraceptive methods declined modestly, from 20.7 per cent in 1994 to 18.5 per cent in 2012.[242] Ninety per cent of women with unmet need today live in developing countries, with the greatest need among women and men in Africa. In 28 sub-Saharan African countries, including all countries in West Africa with the exception of one, fewer than 25 per cent of women of reproductive age used contraception, with unmet need as high as 36 per cent.[243]

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[242] United Nations, Department of Economic and Social Affairs, *World Contraceptive Use 2012*.

[243] J. Cleland and I. Shah, "The contraceptive revolution: focused efforts are still needed", *The Lancet*, vol. 381, No. 9878 (2013), pp. 1604-1606; Alkema and others, "National, regional, and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015".

351. Findings from the global survey indicate that approximately 8 out of 10 countries addressed increasing women's access to information and counselling on sexual and reproductive health (84 per cent) and increasing men's access to sexual and reproductive health information, counselling, and services (78 per cent) during the previous five years. Similarly, 8 out of 10 countries reported having addressed the issue of increasing access to comprehensive sexual and reproductive health services for women (82 per cent) as well as for adolescents (78 per cent). However, this percentage decreased in the case of providing sexual and reproductive health services to persons with disabilities (55 per cent) and indigenous peoples and cultural minorities (62 per cent).

Human rights elaborations since the International Conference on Population and Development

Box 15

Contraceptive information and services

Other soft law. Article 12 of the Convention on the Elimination of All Forms of Discrimination against Women (1979; entry into force 1981) provides that States "shall take all appropriate measures to eliminate discrimination against women in the field of health care in order to ensure, on a basis of equality of men and women, access to health care services, including those related to family planning" (art. 12 (1)). Further, article 16 (1) (e) protects women's right "to decide freely and responsibly on the number and spacing of their children and to have access to the information, education and means to enable them to exercise" this right. Building on these standards, recognizing the correlation between unmet need for contraceptives and higher rates of pregnancy among adolescents, abortion and maternal mortality, and that barriers to access to contraception disproportionately affect certain populations, treaty monitoring bodies have urged States since 1994 to ensure access to medications on the WHO Essential Medicines List, including hormonal contraception and emergency contraception. In elaborating State obligations under article 12 of the International Covenant on Economic, Social, and Cultural Rights, the Committee on Economic, Social and Cultural Rights, in general comment No. 14 on the right to the highest attainable standard of health (2000) urges that "States should refrain from limiting access to contraceptives and other means of maintaining sexual and reproductive health, from censoring, withholding or intentionally misrepresenting health-related information, including sexual education and information, as well as from preventing people's participation in health-related matters". Further, general comment No. 15 on the right of the child to the enjoyment of the highest attainable standard of health (2013) adopted by the Committee on the Rights of the Child states, "Short-term contraceptive methods such as condoms, hormonal methods and emergency contraception should be made easily and readily available to sexually active adolescents. Long-term and permanent contraceptive methods should also be provided."

(a) Contraceptive method mix

352. Over the past 20 years, the diversification of modern contraceptive method mix has been considerable, and the direction of product innovations has been towards innovations that ease administration (and removal), lower doses and reduce side effects.[244] Yet the current array of contraceptive products is not without risks of failure and side effects, some of them serious, and many women have clinical contraindications for specific methods. Because clients differ in their method preferences and clinical needs, including over their own life course, a range of distinct contraceptive method types is a hallmark of safety and quality in human rights-based family planning services, and additional choices of method typically increase overall use.

353. In 1994, the global contraceptive method mix was dominated by female sterilization and the intrauterine device, which captured 31 and 24 per cent of overall contraceptive use, respectively, followed by pills at 14 per cent of global use.[245] Twenty years later, these three methods continue to dominate, but they are accompanied by greater diversification of female methods, including increased use of injectables and implants, and a rise in the use of male condoms. Single methods that predominated in selected countries in the 1990s continue to do so (see figure 27), suggesting limited product choice and/or limited capacity among service providers in these countries.[246]

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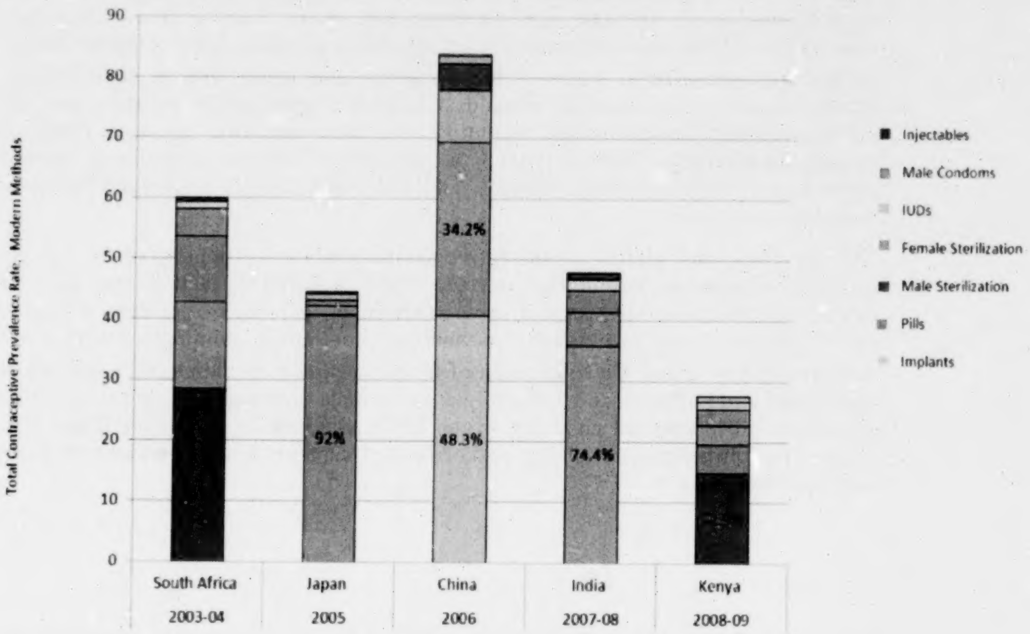
[244] V. Brache and A. Faundes, "Contraceptive vaginal rings: a review", *Contraception* 2010, vol. 82, No. 5 (2010), pp. 418-427; Reproductive Health Supplies Coalition, "Caucus on new and underused reproductive health technologies: contraceptive implants", July 2013, available from http://www.fhi360.org/sites/default/files/media/documents/rhsc-brief-contraceptive-implants_A4.pdf; L. Bahamondes, "Subdermal implantable contraceptives versus other forms of reversible contraceptives or other implants as effective methods of preventing pregnancy", RHL commentary, in *The WHO Reproductive Health Library* (Geneva, World Health Organization, last revised 1 December 2008); available from http://apps.who.int/rhl/fertility/contraception/CD001326_bahamondesl_com/en/; A. Nelson, "New low-dose extended-cycle pills with levonorgestrel and ethinyl estradiol: an evolutionary step in birth control", *International Journal of Women's Health*, vol. 2 (2010), pp. 99-106.

[245] A. Biddlecom and V. Kantorova, "Global trends in contraceptive method mix and implications for meeting the demand for family planning", paper presented to the XXVII International Union for the Scientific Study of Population (IUSSP) International Population Conference, Busan, Republic of Korea, August 2013; model-based estimates based on, inter alia, Alkema and others, "National, regional, and global rates and trends in contraceptive prevalence and unmet need for family planning between 1990 and 2015", using method-mix computations based on *World Contraceptive Use 2012*.

[246] South Africa, Demographic and Health Surveys (DHS), final report, 2003-2004; Kenya, DHS Measure, final report, 2008-2009; Japan, Thirteenth National Fertility Survey, 2005; China, National Family Planning and Reproductive Health Survey, 2006; India, District Level Household and Facility Survey (DLHS-3), 2007-2008; quoted in *World Contraceptive Use 2011* (downloaded and analysed 5 September 2013).

Figure 27

Percentage distribution of women aged 15-49, according to contraceptive method use, highlighting single-method dominance in selected countries



Source: South Africa, Demographic and Health Surveys 2003-2004, final report; Kenya, Demographic and Health Surveys, final report, 2008-2009; Japan, Thirteenth National Fertility Survey, 2005; China, National Family Planning and Reproductive Health Survey, 2006; India, District Level Household and Facility Survey, 2007-2008. Quoted in United Nations, *World Contraceptive Use 2011*, available from www.un.org/esa/population/publications/contraceptive2011/contraceptive2011.htm (data downloaded and analysed 5 September 2013).

354. Programmes dominated by single methods may reflect the legacy of past State family planning policies, sustained through public choice and/or routine commodity flows, provider bias, or technical training.[247] Regardless of the reason for programmes dominated by use of a single method, such programmes are unable to respond to the varied needs of women for delaying, spacing and ending reproduction; the varying needs that women have for different contraceptive technologies for health reasons; or user preferences for distinct technical attributes of methods at different phases of their lives, such as for user-controlled and reversible methods, among others.

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[247] E. E. Seiber, J. T. Betrand and T. M. Sullivan, "Changes in contraceptive method mix in developing countries", *International Family Planning Perspectives*, vol. 33, No. 3 (2007); J. J. Brown, L. Bohua and S. S. Padmadas, "A multilevel analysis of the effects of a reproductive health programme that encouraged informed choice of contraceptive method rather than use of officially preferred methods, China 2003-2005", *Population Studies*, vol. 62, No. 2 (2010), cited in "Changing China's contraceptive policy", *International Perspectives on Sexual and Reproductive Health*, vol. 36, No. 4 (December 2010); D. R. Mishell, Jr., "Intrauterine contraception: an under-utilized method of family planning", *European Journal of Contraception and Reproductive Health Care*, vol. 12, No. 1 (March 2007).

355. A criterion of quality family planning programmes is the availability of a selection of methods with distinct clinical features that can be safely and affordably offered to clients. Persistent dominance of a single method in countries highlights the trade-offs that country programmes make between mass provision of a familiar method versus investment in the health system to diversify commodities and ensure the necessary provider expertise for safe delivery and informed counselling for a range of methods.

(b) Emergency contraception

356. Emergency contraception has been included as part of the WHO Model List of Essential Medicines[248] since 1995; is included in norms, protocols and guidelines issued by the International Federation of Gynaecology and Obstetrics; is registered in most developing and developed countries, and registered as a non-prescription product in over 50 countries.[249] Nevertheless, inadequate knowledge and information regarding emergency contraception pose barriers to its use in most countries. A commission recently (2012) found that where emergency contraception is not registered, it is generally due to policies conflating emergency contraception with abortion and general opposition to contraception.[250] The Commission noted that restrictions on access are often due to unnecessary requirements for prescriptions or lack of provision by the public sector, and emergency contraception remains little known by health-care providers.

(c) Male sterilization

357. While the number of men using condoms has increased where HIV is of concern, male participation in modern family planning has advanced very little since 1994, and there have been very few countries that report increases in male sterilization over the past 20 years.

358. Of 92 countries with more than two data points on the proportion of overall contraceptive prevalence attributable to male sterilization,[251] with at least one data point during or since 2005, 38 countries (41 per cent) reported no use of male sterilization, and in only four countries (the United Kingdom (21 per cent), the Republic of Korea (17 per cent), the United States of America (14 per cent) and Bhutan (13 per cent)) did male sterilization contribute to more than 10 per cent of contraceptive prevalence. Twenty-seven countries (29 per cent) have seen declines in the relative use of male sterilization since 1994, among them Sri Lanka (-4 per cent), India (-2 per cent), Thailand (-2 per cent), Myanmar (-1.4 per cent) and the United States of America (-0.5 per cent), suggesting either absolute declines in the

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[248] WHO, WHO Model List of Essential Medicines, 18th ed. (Geneva, April 2013); available from http://apps.who.int/iris/bitstream/10665/93142/1/EML_18_eng.pdf.

[249] International Consortium for Emergency Contraception, Emergency Contraception in National Essential Medicines Lists (December 2013); available from www.cecinfo.org/custom-content/uploads/2014/01/ICEC_EC-in-EMLs_Dec-2013.pdf. .

[250] Case study prepared for the United Nations Commission on Life-saving Commodities for Women and Children, available from www.everywomaneverychild.org/resources/un-commission-on-life-saving-commodities/life-saving-commodities/emergency-contraception.

[251] See *World Contraceptive Use 2012* (footnote 240 above). The first data point is closest to 1994 and one other is closest to 2012, with the cut-off point at 2005. Of the 194 original countries, 26 were excluded for lack of data; 33 were excluded because they had only one data point; and 43 were excluded because their last data point was before 2005.

use of male sterilization or increased reliance on other (largely female) contraceptive methods.[252]

359. In 2002, 180 million women relied on female sterilization, compared with 43 million men who relied on male sterilization.[253] This disparity is especially striking given that female sterilization is more expensive, incurs more health risks and is irreversible, in contrast to the relatively safe and reversible procedure for males. Research into male hormonal contraception continues to advance, slowly.[254]

360. **States must, as a matter of urgency, provide widespread and high-quality information and counselling regarding the benefits and risks of a full range of affordable, accessible, quality contraceptive methods, with special attention to dual-method use with male or female condoms given the continuing risk of sexually transmitted infections and HIV, and ensure access to both contraceptive knowledge and commodities irrespective of marital status.**

4. Abortion

361. The use of abortion reflects many circumstances that can be difficult for women to prevent, such as contraceptive failure, lack of knowledge about the fertile period or how to use contraception, shortfalls in access or affordability of contraceptives, changing fertility aspirations, disparities in the desire for a pregnancy between a woman and her partner, fear of asking a partner to use contraception, and unplanned or forced sex.[255] Rates of abortion vary dramatically between countries (see table 1)[256] and recent estimates suggest declines in both the rate of abortion, and abortion-related deaths, with the following trends:

(a) The risk of death due to complications of unsafe abortion is decreasing at both global and regional levels.[257] This improvement is widely attributed to improved technologies, increased use of the WHO guidelines for safe abortion and post-abortion care, and greater access to safe abortion;

(b) At 460 and 160 deaths per 100,000 unsafe abortions,[257] the death rates from abortion in Africa and Asia respectively are still shockingly high;

(c) The overall rate of abortions declined globally from 35 abortions per 1,000 women aged 15-44 years in 1995 to 28 per 1,000 in 2003, and remained stable at 29 per 1,000 in 2008;[255]

(d) The absolute numbers of estimated abortions declined from 45.6 million in 1995 to 41.6 million in 2003, then increased to 43.8 million in 2008.[255] This increase is attributable to stagnation in the rate of abortions from 2003 to 2008 coupled with population growth over time;

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[252] J. E. Darroch, "Male fertility control: where are the men?", *Contraception*, vol. 78, No. 4 (2008), pp. S7-S17.

[253] EngenderHealth, *Contraceptive Sterilization: Global Issues and Trends* (New York, 2002), chap. 2.

[254] J. K. Amory and W. J. Bremner, "Newer agents for hormonal contraception in the male", *Trends in Endocrinology and Metabolism*, vol. 11, No. 2 (2000), pp. 61-66.

[255] Gilda Sedgh and others, "Induced abortion: incidence and trends worldwide from 1995 to 2008", *The Lancet*, vol. 379, No. 9816 (18 February 2012), pp. 625-632.

[256] Data compiled from Gilda Sedgh and others, "Legal abortion worldwide: incidence and recent trends", *International Family Planning Perspectives*, vol. 33, No. 3 (September 2007), pp. 106-116.

[257] WHO, *Unsafe Abortion: Global and Regional Estimates of the Incidence of Unsafe Abortion and Associated Mortality in 2008*, 6th ed. (Geneva, 2011).

(e) The highest subregional abortion rates were in Eastern Europe (43 per 1,000 women), the Caribbean (39), East Africa (38) and South-East Asia (36); the lowest subregional rate was in Western Europe (12);[255]

(f) An estimated 86 per cent of all abortions took place in the developing world in 2008, the last year of available estimates.[255]

362. Governments committed themselves in the Programme of Action, as well as in the key actions for the further implementation of the Programme of the Action, to place the highest priority on preventing unwanted pregnancies, and thereby making "every attempt ... to eliminate the need for abortion". Key requirements for fulfilling that commitment are ensuring good public knowledge regarding the risk of pregnancy, strong gender equality norms, and affordable access to a range of safe contraceptive methods with different attributes that would enable most women and men to secure a method that conforms to their needs and any contraindications. Increased use of contraceptives may sometimes correspond to a direct decline in the rates of abortion, as observed in Italy over a 20-year period (see figure 28).[258] While the interaction between the rate of abortion and the use of modern contraception is affected by other conditions, such as fertility aspirations, when fertility rates are held constant over time, increased use of effective modern contraception corresponds to a reduction in the rate of abortions.[259]

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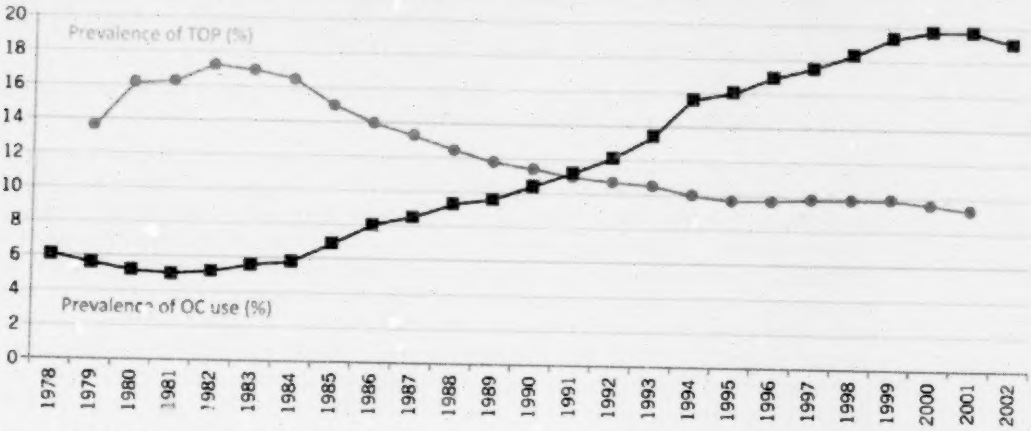
[258] Bustreo and others, *Women's and Children's Health: Evidence of Impact of Human Rights* (see footnote 183 above); G. Benagiano, C. Bastianelli and M. Farris, "Contraception: a social revolution", *European Journal of Contraception and Reproductive Health Care*, vol. 12, No. 1 (2007), pp. 3-12.

[259] C. Marston and J. Cleland, "Relationships between contraception and abortion: a review of the evidence", *International Family Planning Perspectives*, vol. 29, No. 1 (2003), pp. 6-13.

Figure 28

Rates of voluntary termination of pregnancy and use of oral contraceptives among women of reproductive age, Italy, 1978-2002



Source: WHO, *Women and Children's Health: Evidence of Impact of Human Rights* (Geneva, 2013), figure 2D.4. Available from http://apps.who.int/iris/bitstream/10665/84203/1/9789241505420_eng.pdf.
Abbreviations: TOP = termination of pregnancy; OC = oral contraceptive.

363. Gender equality can affect the risk of abortion by a variety of means, for example, by shifting social expectations for more couple conversations about contraception,[260] by the repeal of discriminatory laws such as spousal notification/authorization laws, or by adopting stronger laws that reduce the threat of intimate-partner violence.[261]

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[260] M. Do and N. Kurimoto, "Women's empowerment and choice of contraceptive methods in selected African countries", *International Perspectives on Sexual and Reproductive Health*, vol. 38, No. 1 (2012), pp. 23-33; I. H. Mosha and R. Ruben, "Communication, knowledge, social network and family planning utilization among couples in Mwanza, Tanzania", *African Journal of Reproductive Health*, vol. 17, No. 3 (2013), pp. 57-69; A. A. Bawah, "Spousal communication and family planning behavior in Navrongo: a longitudinal assessment", *Studies in Family Planning*, vol. 33, No. 2 (2002), pp. 185-194; W. I. De Silva, "Husband-wife communication and contraceptive behaviour in Sri Lanka", *Journal of Family Welfare*, vol. 40, No. 2 (1994), pp. 1-13.

[261] G. E. Ely and M. D. Otis, "An examination of intimate partner violence and psychological stressors in adult abortion patients", *Journal of Interpersonal Violence*, vol. 26, No. 16 (2011), p. 3248; D. K. Kaye and others, "Domestic violence as risk factor for unwanted pregnancy and induced abortion in Mulago Hospital, Kampala, Uganda", *Tropical Medicine and International Health*, vol. 11, No. 1 (2006), pp. 90-101; T. W. Leung and others, "A comparison of the prevalence of domestic violence between patients seeking termination of pregnancy and other general gynecology patients", *International Journal of Gynecology and Obstetrics*, vol. 77, No. 1 (2002), pp. 47-54; D. Kaye, "Domestic violence among women seeking post-abortion care", *International Journal of Gynecology and Obstetrics*, vol. 75, No. 3 (2001), pp. 323-325; IPAS, "Youth perspectives reveal abortion stigma and gender inequity are barriers to education on safe abortion", available from www.ipas.org/en/News/2013/October/Youth-perspectives-reveal-abortion-stigma-and-gender-inequity-are-barriers-to-education-on.aspx.

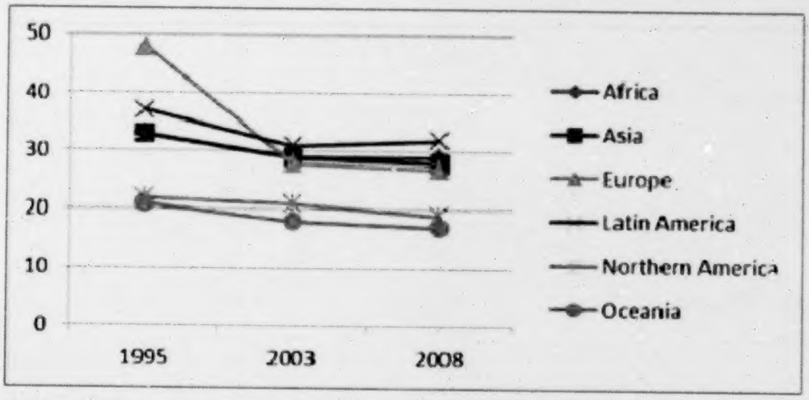
364. Although there were declines in abortion rates across all regions between 1996 and 2003, the most significant decline was in Europe[255] (see figure 29), reflecting relatively high rates of abortion in Eastern Europe in 1996, and steep declines in those rates by 2003. Abortion rates have been much lower and relatively stable over time in Western Europe.

365. Low rates of abortion in Western Europe reflect widespread access to contraceptive knowledge and methods, including comprehensive sexuality education for young people, as well as a high level of gender equality. These factors have created an enabling environment for the use of contraception, and lower abortion rates.

366. **States should strive to eliminate the need for abortion by providing universal access to comprehensive sexuality education starting in adolescence, and sexual and reproductive health services, including modern methods of contraception, to all persons in need; by providing widespread affordable access to male and female condoms, and timely and confidential access to emergency contraception; by implementing school and media programmes that foster gender-equitable values and couple negotiations over issues of sex and contraception; and by respecting, protecting and promoting human rights through the enforcement of laws that allow women and girls to live free from gender-based violence.**

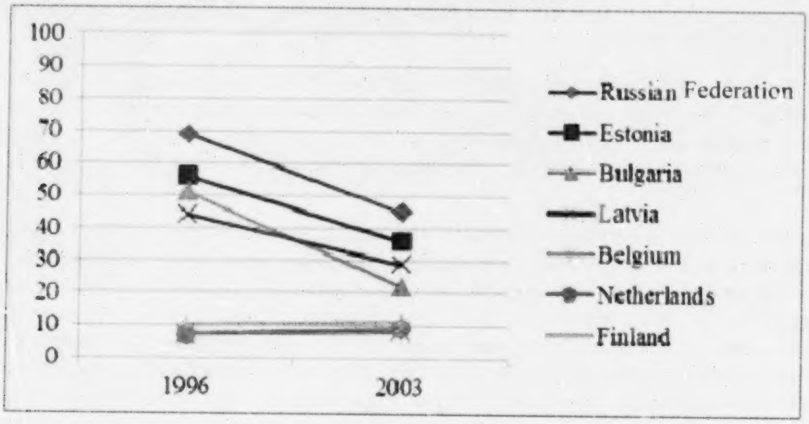
Figure 29

Abortions per 1,000 women aged 15-44 years, weighted regional estimates, 1995, 2003 and 2008



Source: Figure based on data reported in G. Sedgh and others, "Induced abortion: incidence and trends worldwide from 1995 to 2008", *The Lancet*, vol. 379, No. 9816 (18 February 2012).

Figure 30
Abortions per 1,000 women aged 15-44 years in selected European countries where abortion is legally available, 1996 and 2003



Source: Figure based on data reported in G. Sedgh and others, “Induced abortion: incidence and trends worldwide from 1995 to 2008”, *The Lancet*, vol. 379, No. 9816 (18 February 2012).

Table 1
Measures of legal abortion where reporting is relatively complete, 2001-2006

Country/territory	*Year of last available estimate*	*Number of abortions per 1,000 women aged 15-44*	*Number of abortions per 100 live births*
Cuba	2004	57	109
Russian Federation	2003	45	104
Estonia	2003	36	82
Belarus	2003	35	91
Latvia	2003	29	69
Hungary	2003	26	57
Bulgaria	2003	22	52
United States of America	2003	21	31
New Zealand	2003	21	33
Australia	2003	20	34
Sweden	2003	20	34
Puerto Rico	2001	18	28
England and Wales	2003	17	29
France	2003	17	26
Slovenia	2003	16	40
Lithuania	2003	15	38
Denmark	2003	15	24
Norway	2003	15	25
Canada	2003	15	31
Singapore	2003	15	31

Country/territory	*Year of last available estimate*	*Number of abortions per 1,000 women aged 15-44*	*Number of abortions per 100 live births*
Israel	2003	14	14
Czech Republic	2003	13	29
Slovakia	2003	13	31
Scotland	2003	12	23
Italy	2003	11	25
Finland	2003	11	19
Netherlands	2003	9	14
Germany	2003	8	18
Belgium	2003	8	14
Switzerland	2003	7	15
Tunisia	2000	7	9
South Africa	2003	6	6
Nepal	2006	5	4

Source: Data compiled from G. Sedgh and others, "Induced abortion: incidence and trends worldwide from 1995 to 2008", *The Lancet*, vol. 379, No. 9816 (18 February 2012).

367. The decline in abortion rates in Eastern Europe reflects increasing availability and use of modern family planning services and commodities after the break-up of the Soviet Union. However, the persistence of comparatively higher estimated rates of abortion for the period 2001-2005 (Russian Federation (45 per 1,000 women), Estonia (36), Belarus (35), Bulgaria (26) and Latvia (29))[256] coinciding with rates of modern contraception use that are comparable to those in Western Europe (contraceptive prevalence rates for any year available from 2000 to 2006 are: Russian Federation (64.6 per cent of women aged 15-49), Estonia (57.9 per cent), Belarus (56 per cent), Bulgaria (40.1 per cent) and Latvia (55.5 per cent)),[262] suggest a lag in effective use behaviour, or possible contraceptive failure. A similar discordance is evident in Cuba, which has among the highest abortion rates in the world (57 per 1,000 women aged 15-44),[256] and yet comparatively high reported rates of modern contraceptive use; its contraceptive prevalence rate was 72.1 per cent in 2000 and 71.6 per cent in 2006.[262] These cases underscore that access to contraception is necessary, but may not be sufficient, to reduce abortion, and that other cultural behaviours may demand understanding and intervention, including the social and symbolic meaning associated with the use of contraception in certain relationships, norms for communication between partners, social expectations of sexual practice, the local meaning associated with abortion, and the risk of forced sex.

368. Important gains have been made in reducing deaths due to unsafe abortion since 1994, most notably in countries that have undertaken complementary and comprehensive changes in both law and practice to treat abortion as a public health concern (see the case study of Uruguay, below). Nonetheless, the number of abortion-related deaths has held steady in recent years even as maternal deaths overall have continued to fall. As of 2008, an estimated 47,000 maternal deaths were

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[262] Contraceptive prevalence rate data from the Millennium Development Goals indicators database (http://mdgs.un.org/unsd/mdg/data.aspx).

attributed to unsafe abortion, a decline from 69,000 deaths in 1990.[263] But given that the number of deaths due to unsafe abortion has declined more slowly than the overall number of maternal deaths, unsafe abortions appear to account for a growing proportion of maternal deaths globally.[264]

Case study — Eliminating maternal deaths resulting from unsafe abortions

Uruguay

Since 2001 Uruguay has achieved important progress in the reduction of maternal deaths resulting from unsafe abortions through the implementation of the *Modelo Uruguayo de Prevención de Riesgo y Daño*. The model is based on commitments to fulfil the Programme of Action of the International Conference on Population and Development. It aims to reduce the risks and morbidities caused by unsafe abortions, which accounted for 42 per cent of maternal deaths in 2001, 28 per cent in 2002 and 55 per cent in 2003.

The model is based on three pillars: respect for a woman's decision; confidentiality and committed professional practice; and treating abortions as a public health issue rather than a legal or criminal matter. All women, including adolescents, have access to a multidisciplinary team of gynaecologists, midwives, psychologists, nurses and social workers who provide pre- and post-abortion information, counselling and care, including information on alternatives to abortion, existing abortion methods and their risks, within a comprehensive health-care approach that includes the management of complications, rehabilitation and access to contraception. A key to success is the fact that all sexual and reproductive health professionals are trained to provide pre- and post-abortion counselling.

Encouraging results were observed shortly after the implementation of the model. From 2004 to 2007 Uruguay registered a maximum of two cases of maternal deaths from unsafe abortion, and from 2008 to 2011 reached zero maternal deaths from unsafe abortion. According to WHO, this model can be adapted and replicated in other countries' abortion laws.

In 2012 Uruguay became the third country in Latin America, after Cuba and Guyana, to decriminalize abortion, through the Law on the Voluntary Termination of Pregnancy, which guarantees a woman's right to safe abortion during the first 12 weeks of pregnancy, and 14 weeks in case of rape. Adolescents are included in this law under the notion of "progressive autonomy", based on article 8 of the Child and Adolescent Code, which refers to the development process of the evolving capacities of each individual to enable the fulfilment of all rights.

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[263] E. Ahman and I. Shah, "New estimates and trends regarding unsafe abortion mortality", *International Journal of Gynecology and Obstetrics*, vol. 115, No. 2 (2011), pp. 121-126.

[264] K. Ringheim, "Sexual and reproductive health and rights thematic report", background document prepared for the review of the Programme of Action beyond 2014 (June 2013).

These initiatives, together with the Law on the Protection of the Right to Sexual and Reproductive Health Care (2008), which requires public and private health providers to provide comprehensive sexual and reproductive health services, including private and confidential counselling and access to free, quality contraception in public services, and the Sexuality Education Act (2009), which institutionalizes sex education at all levels of formal education, from kindergarten to teacher training, have contributed to Uruguay's attainment of the lowest maternal mortality rate in Latin America and the third lowest in the Americas. In the last year for which data are available, 2012, the maternal mortality ratio in Uruguay was 10.3 per 100,000 live births.

369. Nearly all (97 per cent) abortions in Africa (outside of Southern Africa) and in Central and South America remain unsafe.[255] But this figure masks dramatic differences between the regions in the risk of death due to abortion, which is 15 times higher in Africa than in Latin America and the Caribbean.[263] It is also Africa that has seen the least decline in the number of deaths due to unsafe abortion since 1990.[265] The estimated decline in deaths in Latin America was from 80 to 30 per 100,000 abortions, whereas in Africa the number of deaths declined from the staggering rate of 680 deaths per 100,000 abortions to 460 (520 in sub-Saharan Africa).[265]

370. The Programme of Action acknowledged that unsafe abortion was a major public health concern, and that Governments had a responsibility to provide for post-abortion care and counselling. In 1995, WHO developed technical recommendations to improve the quality of abortion-related services where such services were legal, and the urgent care of women arriving with post-abortion complications; the latter was of particular relevance to countries where abortion was not legal.[266] In 1999, with the five-year review of the Programme of Action WHO began a series of consultations that resulted in the publication of *Safe Abortion: Technical and Policy Guidance for Health Systems*, which was approved in July 2003 and issued in the official and numerous non-official WHO languages. Several agencies attribute the recent decline in abortion-related case fatalities to the growing use of the guidelines contained in this publication.

371. **States should take concrete measures to urgently reduce abortion-related complications and deaths by increasing access to non-discriminatory post-abortion care for all women suffering from complications of unsafe abortion, and ensure that all providers take action as indicated in the WHO publication *Safe Abortion: Technical and Policy Guidance for Health Systems*, to deliver quality care and remove legal barriers to services. States should remove legal barriers preventing women and girls from access to safe abortion, including revising restrictions within existing abortion laws, in order to safeguard the lives of women and girls and, where abortion is legal, ensure that all women have ready access to safe, good-quality abortion services.**

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[265] World Health Organization, *Safe Abortion: Technical and Policy Guidance for Health Systems*, 2nd ed. (Geneva, 2012).

[266] P. F. A. Van Look and J. Cottingham, "The World Health Organization's safe abortion guidance document", *American Journal of Public Health*, vol. 103, No. 4 (April 2013), pp. 593-596.

372. The global survey found that only 50 per cent of countries addressed the issue of access to "safe abortion to the extent of the law" during the previous five years. A larger proportion of countries (65 per cent) did, however, address the issue of "prevention and management of the consequences of unsafe abortion". The proportion of Governments addressing this issue was inversely proportional to the wealth of the countries. Thus, while 69 per cent of the lowest-income countries addressed this issue via policy, budget and concrete actions, only 29 per cent of the wealthiest did the same. This may reflect the higher prevalence of unsafe abortions in low-income countries.

373. Access to safe and comprehensive abortion services and to management of the complications of abortion varies widely across and within countries and regions. Regarding management, evidence based on data from the Maternal and Neonatal Program Effort Index underscores that women living in rural areas have significantly less access to such services across most developing countries.[267]

374. When grouping countries by the current status of their abortion laws (most, less and least restrictive),[268] the proportion of countries that addressed the issue of "prevention and management of the consequences of unsafe abortion" was lowest (72 per cent) among countries with the most restrictive laws. Likewise, only 48 per cent of countries with the most restrictive laws addressed the issue of access to "safe abortion to the extent of the law".

Human rights elaborations since the International Conference on Population and Development

Box 16
Abortion

Other soft law. Since 1994 human rights standards have evolved to strengthen and expand States' obligations regarding abortion. In a series of concluding observations, treaty monitoring bodies have highlighted the relationship between restrictive abortion laws, maternal mortality and unsafe abortion;[269] condemned absolute bans on abortion;[270] and urged States to eliminate punitive measures against women and girls who undergo abortions and providers who deliver abortion services.[271] Further, treaty monitoring bodies have emphasized that, at a minimum, States should decriminalize abortion and ensure access to abortion when the pregnancy poses a risk to a woman's health or life, where there is severe foetal abnormality, and where the pregnancy is the result of rape or incest.[272] However, the Human Rights Committee noted that such exceptions might be insufficient to ensure women's human rights, and that where abortion is legal it must be accessible, available, acceptable and of good quality.[273] Regardless of legal status, treaty bodies have highlighted that States must ensure confidential and adequate post-abortion care.[274]

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[267] Analysis based on data from the Maternal and Neonatal Program Effort Index (MNPI) (http://www.policyproject.com/pubs/mnpi/getmnpi.cfm).

[268] United Nations, Department of Economic and Social Affairs, Population Division, *World Abortion Policies 2013*; available from www.unpopulation.org.

[269] Concluding observations of the Committee on the Elimination of Discrimination against Women following the consideration by the Committee of the sixth periodic report of Paraguay (CEDAW/C/PRY/CO/6, para. 31 (a)); and the fourth periodic report of Chile (CEDAW/C/CHI/CO/4, para. 20); concluding observations of the Committee on Economic, Social and Cultural Rights following the consideration by the Committee of the combined second to fourth periodic report of the Philippines (E/C.12/PHL/CO/4, para. 31); concluding observations of the Human Rights Committee following the consideration by the Committee of the third periodic report of Zambia (CCPR/C/ZMB/CO/3, para. 18).

[270] Concluding observations of the Committee against Torture following the consideration by the Committee of the initial report of Nicaragua (CAT/C/NIC/CO/1, para. 16); concluding observations of the Human Rights Committee following the consideration by the Committee of the sixth periodic report of El Salvador (CCPR/C/SLV/CO/6, para. 10); concluding observations of the Committee on Economic, Social and Cultural Rights following the consideration by the Committee of the third periodic report of Chile (E/C.12/1/Add.105, paras. 26 and 53).

Abortions among young women

375. In 2008, 41 per cent (8.7 million) of all unsafe abortions occurred among young women aged 15-24 years in developing countries; of this number 3.2 million unsafe abortions were undergone by 15- to 19-year-olds[275] Young adolescents face a higher risk of complications from unsafe abortions, and women under the age of 25 account for almost half of all abortion deaths.[257] Evidence points to the fact that adolescents are more likely to delay seeking an abortion and, even in countries where abortion may be legal, they resort to unsafe abortion providers owing to fear, lack of knowledge and limited financial resources.[275]

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[271] Committee on the Elimination of Discrimination against Women, general recommendation 24 concerning article 12 of the Convention on the Elimination of All Forms of Discrimination against Women on women and health, adopted by the Committee at its twentieth session (see A/54/38/Rev.1, part one, chap. I, sect. A); concluding observations of the Human Rights Committee following the consideration by the Committee of the fourth report of Costa Rica (CCPR/C/79/Add.107, para. 11); concluding observations of the Committee on the Rights of the Child following the consideration by the Committee of the fourth periodic report of Nicaragua (CRC/C/NIC/CO/4, para. 59 (b)).

[272] Concluding observations of the Committee on the Rights of the Child following the consideration by the Committee of the initial report of Chad (CRC/C/15/Add.107, para. 30); the third periodic report of Chile (CRC/C/CHL/CO/3, para. 56); and the fourth periodic report of Costa Rica (CRC/C/CRI/CO/4, para. 64 (c)); concluding observations of the Human Rights Committee following the consideration by the Committee of the third periodic report of Guatemala (CCPR/C/GTM/CO/3, para. 20); concluding observations of the Committee on Economic, Social and Cultural Rights following the consideration by the Committee of the third periodic report of the Dominican Republic (E/C.12/DOM/CO/3, para. 29); and the third periodic report of Chile (E/C.12/1/Add.105, para. 53).

[273] Concluding observations of the Human Rights Committee following the consideration by the Committee of the fifth periodic report of Poland (CCPR/CO/82/POL, para. 8).

[274] Concluding observations of the Committee on Economic, Social and Cultural Rights following the consideration by the Committee of the second periodic report of Slovakia (E/C.12/SVK/CO/2, para. 24); concluding observations of the Committee on the Elimination of Discrimination against Women following the consideration by the Committee of the fourth periodic report of Chile (CEDAW/C/CHI/CO/4, para. 20).

[275] I. Shah and E. Ahman, "Unsafe abortion differentials in 2008 by age and developing country region: high burden among young women", *Reproductive Health Matters*, vol. 20, No. 39 (2012), pp. 169-173.

Case study: Effective family planning strategies result in very low abortion rates

The Netherlands

The Netherlands provides an excellent example of a country where a pragmatic and comprehensive approach to family planning, especially for young people, has resulted in one of the lowest abortion rates worldwide. By the late 1960s family doctors in the Netherlands offered family planning services. In 1971 family planning was included in the national public health insurance system, providing free contraceptives. Sexual education is universal and comprehensive, and based on common United Nations indicators, Dutch women are the most empowered in the world.[276] Sexually active young people display some of the highest rates of contraceptive use of any youth population and, as a consequence, the Dutch abortion rate fluctuates between 5 and 9 per 1,000 women aged 15-44, one of the lowest rates in the world. Abortion in the Netherlands is legal, safe, easily accessible and rare.[277]

376. Governments committed themselves in the Programme of Action to place the highest priority on preventing unwanted pregnancies, thereby making "every attempt ... to eliminate the need for abortion". Closer examination of policy and practice in countries with a low number of abortions such as the Netherlands may offer valuable lessons on reducing unwanted pregnancies in other countries.

5. Maternal mortality

377. Of all sexual and reproductive health indicators, the greatest gains since 1994 have been made in the maternal mortality ratio. In 1994, more than half a million women died each year from largely preventable causes related to pregnancy and childbirth, and by 2010 the maternal mortality ratio had declined by 47 per cent, from 400 deaths per 100,000 live births in 1990 to 210.[278]

378. However, an estimated 800 women in the world still die from pregnancy or childbirth-related complications each day, and the differences between developed and developing regions remain stark. In 2010, developing countries accounted for 99 per cent of all maternal deaths globally.[278] Women in the developed world have only a 1 in 3,800 lifetime risk of dying of causes related to maternity, while the lifetime risk for those in developing regions is 1 in 150, and in sub-Saharan Africa, the lifetime risk is 1 in 39.[278] While still short of reaching target 5.A, "Reduce by three quarters the maternal mortality ratio", of Millennium Development Goal 5 globally, by 2010, 10 countries had reached this target, with another 9 on track to

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[276] *The World's Women 2010: Trends and Statistics* (United Nations publication, Sales No. E.10.XVII.11).

[277] *Sexual and Reproductive Health: The Netherlands in International Perspective* (2009); available from www.rutgerswpf.org/sites/default/files/Sexual-and-reproductive-health.pdf.

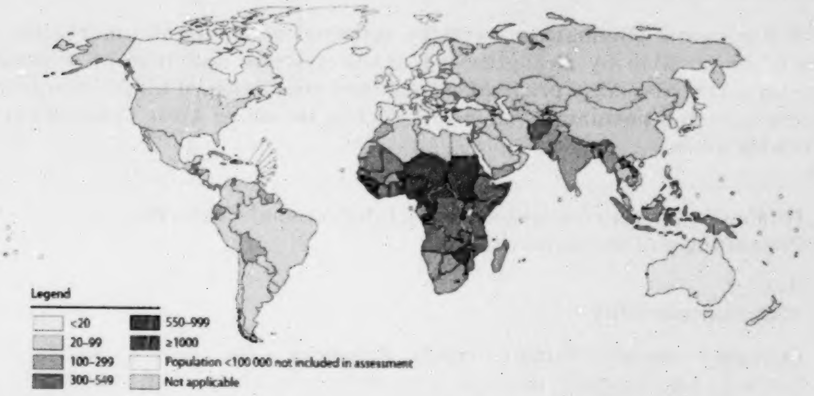
[278] WHO and others, *Trends in Maternal Mortality: 1990-2010 — WHO, UNICEF, UNFPA and the World Bank Estimates* (World Health Organization, Geneva, 2012).

reach it by 2015.[279] However, 26 countries have experienced an increase in maternal deaths since 1990, in large part due to deaths related to HIV, and in sub-Saharan Africa, HIV and maternal causes are now the two predominant causes of women's premature death.[278]

Figure 31

Maternal mortality ratio by country, 2010

(Deaths per 100,000 live births)



Source: *Trends in Maternal Mortality 1990 to 2010: WHO, UNICEF, UNFPA and The World Bank Estimates* (Geneva, WHO, 2012).

Note: Forty countries had high maternal mortality ratios in 2010. Of these countries, only Chad and Somalia had extremely high ratios, at 1,100 and 1,000, respectively. The other eight countries with the highest ratios were: Central African Republic (890), Sierra Leone (890), Burundi (800), Guinea-Bissau (790), Liberia (770), Sudan (730), Cameroon (690) and Nigeria (630). Although most sub-Saharan African countries had high ratios, Mauritius (60), Sao Tome and Principe (70) and Cabo Verde (79) had low maternal mortality ratios while Botswana (160), Djibouti (200), Namibia (200), Gabon (230), Equatorial Guinea (240), Eritrea (240) and Madagascar (240) had moderate ratios. Only four countries outside the sub-Saharan African region had high maternal mortality ratios: Lao People's Democratic Republic (470), Afghanistan (460), Haiti (350) and Timor-Leste (300).

379. Countries with unacceptably high maternal mortality ratios remain concentrated in developing regions, predominantly sub-Saharan Africa, where numerous factors, including poverty and fragile health systems, perpetuate higher rates of maternal death.[278]

380. Post-partum haemorrhage, sepsis, obstructed labour, complications of unsafe abortion and hypertensive disorders — all preventable — are among the leading causes of maternal deaths.[280] Wealth and spatial inequalities in women's access to adequate emergency obstetric care for the management of these conditions abound

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[279] Bangladesh, Cambodia, China, Egypt, Equatorial Guinea, Eritrea, Lao People's Democratic Republic, Nepal and Viet Nam. WHO, *Every Woman, Every Child: From Commitments to Action — The First Report of the Independent Expert Review Group on Information and Accountability for Women's and Children's Health* (Geneva, 2012).

[280] C. Patton and others, "Global patterns of mortality in young people: a systematic analysis of population health data", *The Lancet*, vol. 374, No. 9693 (2009), pp. 881-892.

within countries, highlighting the inadequate reach of skilled providers and quality health services for many poor women, especially in rural or remote areas.

381. Gains in maternal survival over the past 20 years can be attributed in part to advances in the use of antenatal care, skilled attendance at delivery, emergency obstetric care and family planning among select sectors of society, yet the majority of developing countries are not on track to achieve Millennium Development Goal 5 (improving maternal health), with its targets of reducing the maternal mortality ratio by three quarters and achieving universal access to reproductive health by 2015; in no region is the gap more pronounced than in sub-Saharan Africa.[281]

382. **States should eliminate preventable maternal mortality and morbidity as urgently as possible by strengthening health systems and thereby ensuring universal access to quality prenatal care, skilled attendance at birth, emergency obstetric care and postnatal care for all women, including those living in rural and remote areas.**

Human rights elaborations since the International Conference on Population and Development

Box 17

Maternal mortality

Intergovernmental human rights outcomes. The Human Rights Council has adopted multiple resolutions declaring that maternal mortality violates human rights, including resolution 18/2 on preventable maternal mortality and morbidity and human rights (2011), in which the Council recognized that "a human rights-based approach to eliminate preventable maternal mortality and morbidity is an approach underpinned by the principles of, inter alia, accountability, participation, transparency, empowerment, sustainability, non-discrimination and international cooperation", and encouraged "States and other relevant stakeholders, including national human rights institutions and non-governmental organizations, to take action at all levels to address the interlinked root causes of maternal mortality and morbidity, such as poverty, malnutrition, harmful practices, lack of accessible and appropriate health-care services, information and education, and gender inequality, and to pay particular attention to eliminating all forms of violence against women and girls".

(a) Maternal morbidity and reproductive cancers

383. For every woman who dies of pregnancy-related causes, an estimated 20 others experience a maternal morbidity,[282] including severe and long-lasting complications. The underlying causes of maternal morbidity are the same as the underlying causes

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[281] Ahman and Shah, "New estimates and trends regarding unsafe abortion mortality" (see footnote 263 above); World Health Organization and others, *Trends in Maternal Mortality* (see footnote 278 above).

[282] UNFPA, "Surviving childbirth but enduring chronic ill health"; available from www.unfpa.org/public/mothers/pid/4388.

of maternal death,[283] including poverty and lack of skilled care. Most of them, including obstetric fistula, are entirely preventable with skilled care at birth, and emergency obstetric care as a back-up.

384. Obstetric fistula represents the face of failure as a global community to protect the sexual and reproductive health and rights of women and girls, and to achieve equity in the distribution and access to comprehensive sexual and reproductive health services. An estimated 2-3.5 million women live with obstetric fistula in the developing world, mostly in sub-Saharan Africa and Asia where adolescent births are highest and access to emergency obstetric care is low, and between 50,000 and 100,000 new cases occur each year. All but eliminated from the developed world, obstetric fistula continues to affect the poorest of the poor: women and girls living in some of the most underresourced regions in the world.[284] **States should implement measures to ensure the elimination of obstetric fistula through the provision of high-quality maternal health care to all women, and provide for the rehabilitation and reintegration of fistula survivors into their communities.**

385. **Maternal morbidity should be utilized as an indicator of quality sexual and reproductive health services and the progressive realization of women's right to health.**

386. The Programme of Action included commitments to address infertility and cancers of the reproductive systems. Infertility is not only a great personal sadness for many women and couples, but in many parts of the world, a woman's inability to become pregnant is cause for social exclusion and even divorce. The Programme of Action called for prevention and treatment of sexually transmitted infections, a leading cause of secondary infertility, as well as for treatment of infertility where feasible. About 2 per cent of women globally are unable to conceive (primary infertility) and nearly 11 per cent are unable to conceive another child after having had at least one (secondary infertility). In low-income countries, infertility is often caused by sexually transmitted infections and complications from unsafe abortion.[285] Infertility is highest in some countries of South Asia (up to 28 per cent) and sub-Saharan Africa (up to 30 per cent), but primary infertility has declined in South Asia and both types of infertility have declined in sub-Saharan Africa. Owing to population growth, the number of couples affected by infertility globally rose from 42 million in 1990 to 48.5 million in 2010.[286]

387. More than half a million women each year develop cervical cancer, the second most common cancer among women aged 15 to 44 worldwide. More than 275,000 women die of the disease each year, the great majority (242,000) in developing regions, especially sub-Saharan Africa. While the global survey was carried out before widespread appreciation of the impact of the human papilloma virus vaccine,

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[283] See www.who.int/topics/maternal_health/en/, accessed 22 April 2013.

[284] L. Wall and others, "The obstetric vesicovaginal fistula in the developing world", *Obstetrical and Gynecological Survey*, vol. 60, No. 7 (2005), pp. S1-S51; S. Bernstein and D. Hansen, *Public Choices, Private Decisions: Sexual and Reproductive Health and the Millennium Development Goals* (New York, Millennium Project, 2006); Campaign to end fistula (www.endfistula.org); B. Osotimehin, "Obstetric fistula: ending the health and human rights tragedy", *The Lancet*, vol. 381, No. 9879 (18 May 2013), pp. 1702-1703.

[285] WHO, *Women and Health, Today's Evidence, Tomorrow's Agenda* (Geneva, 2009).

[286] M. N. Mascarenhas and others, "National, regional, and global trends in infertility prevalence since 1990: a systematic analysis of 277 health surveys", *PLoS Medicine*, vol. 9, No. 12 (2012).

and therefore did not include questions on that topic, this advancing technology has significant promise for curtailing cervical cancer.[287]

388. Breast cancer was, and remains, the most common cancer among women in high-income countries, currently affecting 70 out of 100,000 women. Incidence is less than half in low-income countries, but because of poor access to diagnosis and treatment, mortality in the developing world is similar to that in developed countries.[285]

389. **States should recognize and address the rising burden of reproductive cancers associated with rising life expectancy, especially breast and cervical cancer, by investing in routine screening at primary care, and referral to skilled cancer providers at higher levels of care.**

(b) Antenatal care

390. The percentage of pregnant women who had at least one antenatal care visit increased globally from 63 per cent in 1990 to 80 per cent in 2010, an overall improvement of approximately 30 per cent. Again, such accomplishments mask regional disparities: Southern Africa had achieved 94 per cent coverage of antenatal care by 2010, whereas in West Africa only 67 per cent of pregnant women had at least one antenatal care visit. In Latin America, nearly all women now have at least one antenatal care visit (96 per cent) and 88 per cent have at least four.[288]

391. According to the global survey, 88 per cent of countries had addressed the issue of "access to antenatal care" in the previous five years. On average, countries that addressed this issue had maternal mortality rates higher than countries that did not report addressing it, suggesting targeted attention by Governments with higher maternal mortality rates at the time of the survey. Furthermore, we can associate greater government attention with a steeper decline in maternal mortality rates; this is most apparent in low-income countries.

392. In spite of a high proportion of countries reported to have addressed the issue of antenatal care, a reduced proportion of countries had adopted policies, budgets and implementation measures for the "provision of adequate food and nutrition to pregnant women" (71 per cent) during the previous five years, and even fewer reported addressing the issue of "providing social protection and medical support for adolescent pregnant women" (65 per cent).

(c) Skilled attendance at birth

393. The proportion of deliveries attended by skilled health personnel rose in developing countries, from 56 per cent in 1990 to 67 per cent in 2011. Despite the positive trends, access to good maternal health care remains highly inequitable across regions, and within countries between poor and wealthier women. The likelihood of having skilled attendance at birth is most correlated with wealth, as

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[287] WHO/ICO Information Centre on HPV and Cervical Cancer, *Human Papillomavirus and Related Cancers in World: Summary Report 2010*, updated 15 November 2010; available from www.hpvcentre.net/; and International Agency for Research on Cancer (www.iarc.fr).

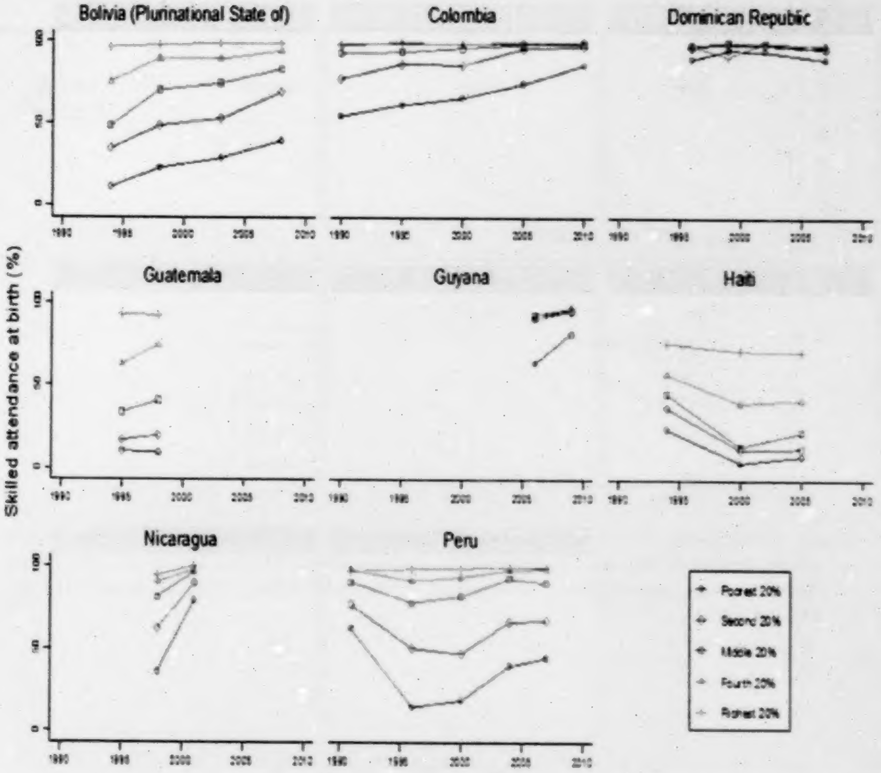
[288] International Federation of Red Cross and Red Crescent Societies and Partnership for Maternal, Newborn and Child Health, *Eliminating Health Inequities: Every Woman and Every Child Counts* (Geneva, International Federation of Red Cross and Red Crescent Societies, 2011); *The Millennium Development Goals Report 2012* (United Nations publication, Sales No. E.12.I.4).

illustrated by the differential progress within countries when stratified by household wealth quintiles (see figures 32 to 35).

394. Comparing figures 32 to 36 with figures 23 to 26 reveals that the distribution of the contraceptive prevalence rate by household wealth quintiles is more equitable than the distribution of skilled birth attendance, with greater outreach to the poor. Indeed, contraception is operationally far easier for weak health systems to offer than skilled birth attendance, as pill or condom distribution does not rely on the availability of skilled health workers to respond urgently to a woman in need, and can be passively provided long in advance of actual need. Disparities in skilled attendance highlight the limited capacity of many existing health systems to provide fundamental sexual and reproductive health care to poor women.

Figure 32

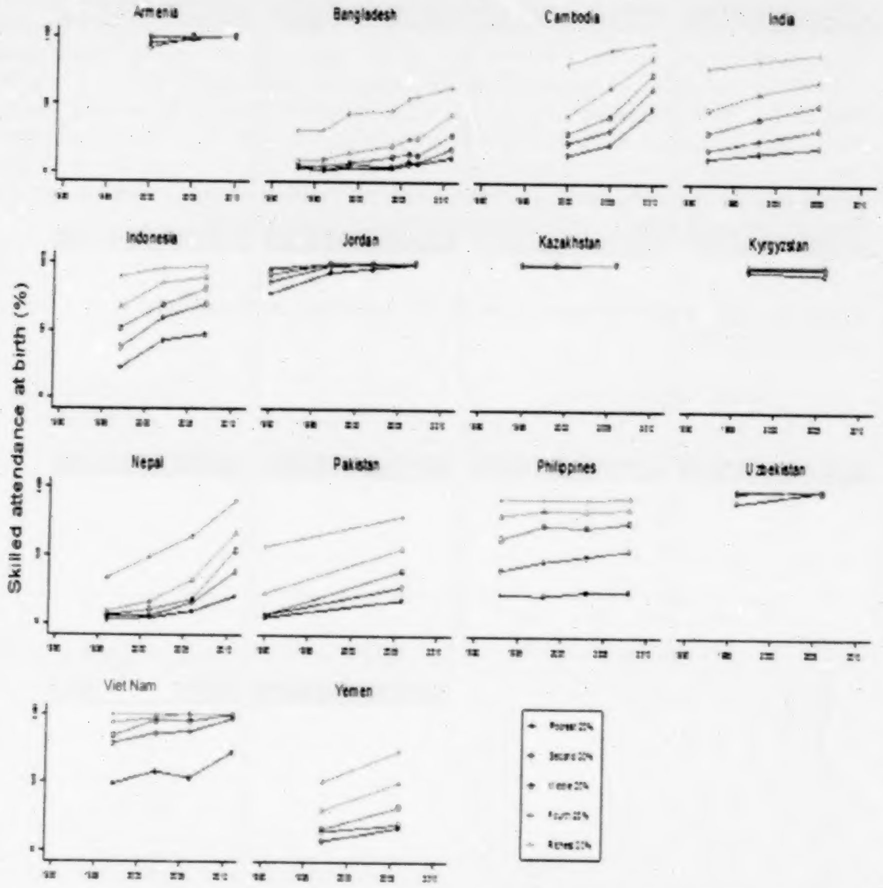
Trends in skilled attendance at birth in the Americas, by household wealth quintiles



Source: Demographic and Health Surveys, all countries with available data for at least two time points. Available from www.measuredhs.com (accessed on 15 June 2013); Multiple indicator cluster surveys, available from www.unicef.org/statistics/index_24302.html (accessed 15 June 2013).

Figure 33

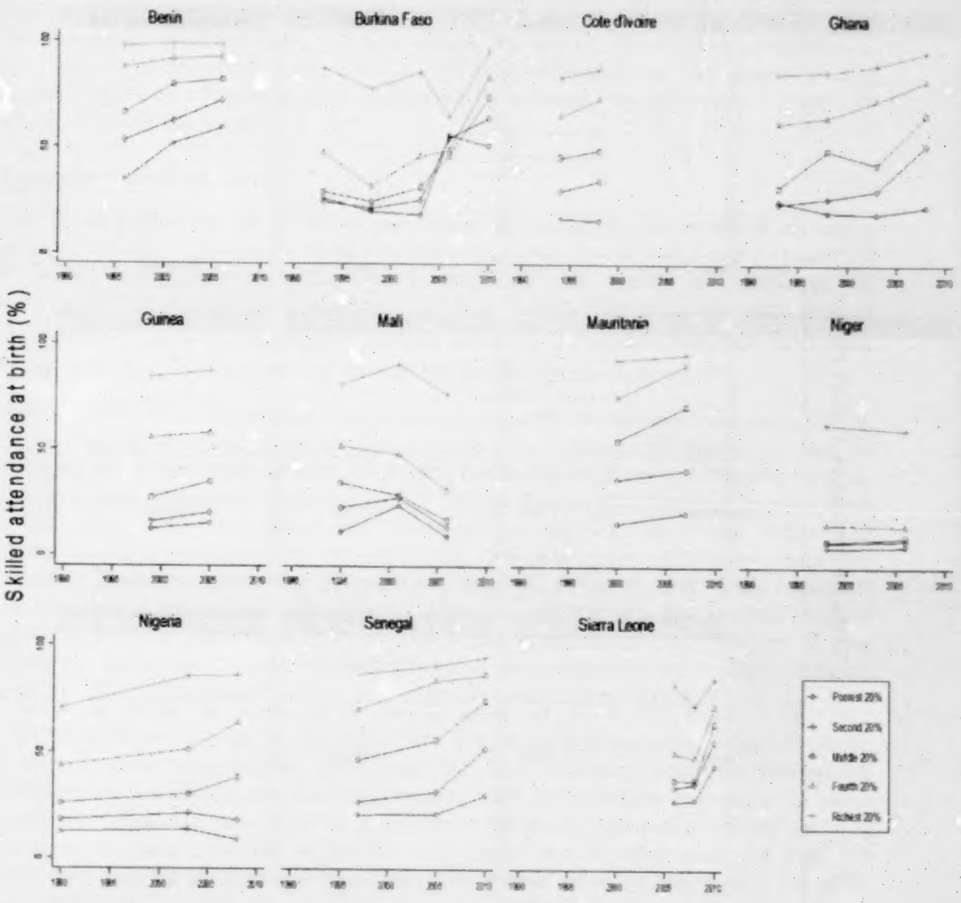
Trends in skilled attendance at birth in Asia, by household wealth quintiles



Source: Demographic and Health Surveys, all countries with available data for at least two time points. Available from www.measuredhs.com (accessed on 15 June 2013); multiple indicator cluster surveys, available from www.unicef.org/statistics/index_24302.html (accessed on 15 June 2013).

Figure 34

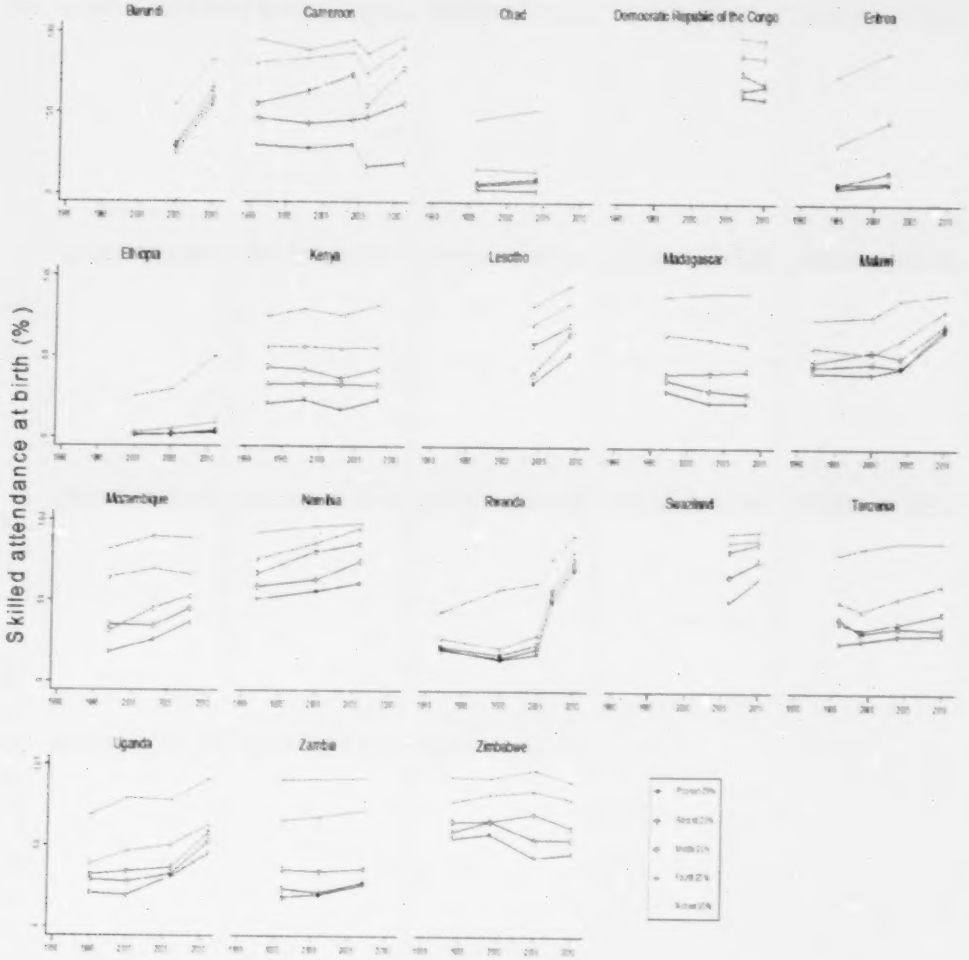
Trends in skilled attendance at birth in Northern and Western Africa, by household wealth quintiles



Source: Demographic and Health Surveys, all countries with available data for at least two time points. Available from www.measuredhs.com (accessed on 15 June 2013); multiple indicator cluster surveys, available from www.unicef.org/statistics/index_24302.html (accessed on 15 June 2013).

Figure 35

Trends in skilled attendance at birth in Eastern, Middle and Southern Africa, by household wealth quintiles



Source: Demographic and Health Surveys, all countries with available data for at least two time points. Available from www.measuredhs.com (accessed 15 June 2013); multiple indicator cluster surveys, available from www.unicef.org/statistics/index_24302.html (accessed 15 June 2013).

395. Differences in access among urban and rural women are also strikingly inequitable, with rural women much less likely than urban women to have a skilled attendant during delivery. This is driven in part by a profound health worker shortage in the 58 countries in which 91 per cent of maternal deaths occur. In the

aggregate, little progress was seen in skilled birth attendance in sub-Saharan Africa as a region, where fewer than half of all births are attended by skilled personnel.[289]

396. The availability and accessibility of skilled attendance at birth provided by adequately trained health-care personnel ensures a safe, normal delivery for every woman, significantly reducing the risks of delivery complications and thus the need for emergency obstetric care. For this reason, the use of skilled birth attendance is not only cost-effective, but also a valuable indicator of the maturity and sophistication of a health system, indicating its accessibility and responsiveness to all, particularly the poor.

(d) Emergency obstetric care

397. Even in the context of skilled attendance at birth, delivery complications arise in approximately 15 per cent of all pregnancies, a majority of which can be managed if quality emergency obstetric care is available and rapidly accessible to all women.[290] Yet in 2010 approximately 287,000 women died from complications of pregnancy,[291] with millions more women suffering chronic morbidities, testimony to the lack of equitable access to emergency health care for women.[292]

398. All five of the major causes of maternal mortality — post-partum haemorrhage, sepsis, unsafe abortion, hypertensive disorders and obstructed labour — can be managed when well-trained staff with adequate equipment are available to provide the necessary emergency obstetric care.[292] Basic emergency obstetric care services include the ability to: administer parenteral antibiotics, uterotonic drugs and parenteral anticonvulsants for pre-eclampsia and eclampsia; remove placenta and retained products; and provide assisted vaginal delivery and basic neonatal resuscitation. Comprehensive emergency obstetric care services also include surgical skills to perform caesarean sections and blood transfusions. A minimum of five facilities, including at least one that provides comprehensive emergency obstetric care, per 500,000 population is recommended for adequate coverage.[293]

399. Since 1994 emergency obstetric care has become a key component of global maternal mortality reduction initiatives. Yet in developing countries emergency obstetric care coverage remains inadequate, with an insufficient number of basic emergency obstetric care facilities in countries that have high and moderate levels of maternal mortality. Further, a majority of facilities that offer maternal care are unable to provide all services required to be classified as an emergency obstetric care facility.

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[289] UNFPA, *The State of the World's Midwifery 2011: Delivering Health, Saving Lives* (New York, 2011).

[290] See UNFPA, "Emergency obstetric care checklist for planners"; available from www.unfpa.org/upload/lib_pub_file/150_fileneame_checklist_MMU.pdf.

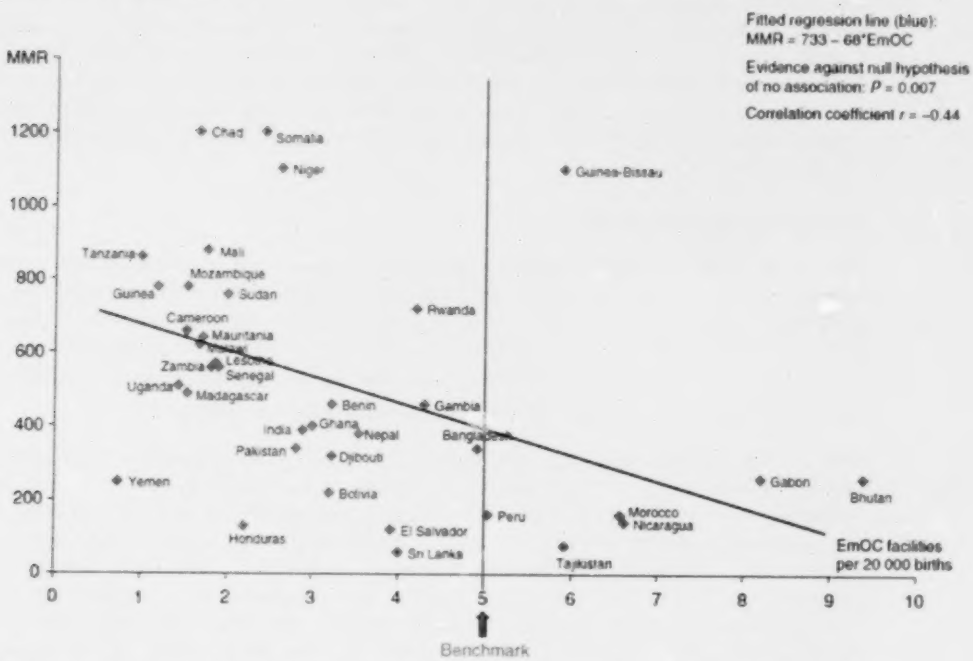
[291] Millennium Development and Beyond, Factsheet on target 5.A (www.un.org/millenniumgoals/maternal.shtml).

[292] UNFPA, "Setting standards for emergency obstetric and newborn care" (see www.unfpa.org/public/home/mothers/pid/4385, accessed 12 December 2013).

[293] WHO and others, *Monitoring Emergency Obstetric Care: A Handbook* (Geneva, World Health Organization, 2009).

Figure 36

Association between emergency obstetric care facility density per 20,000 births and maternal mortality



Source: S. Gabrysch, P. Zanger P and O. M. R. Campbell, "Emergency contraceptive care availability: a critical assessment of the current indicator", *Tropical Medicine and International Health*, vol. 17, No. 1 (January 2012), pp. 2-8.

Abbreviations: MMR = maternal mortality rate; EmOC = emergency obstetric care.

Note: The figure was created by the authors using data from *Trends in Maternal Mortality 1990 to 2010. WHO, UNICEF, UNFPA and The World Bank Estimates* (Geneva, WHO, 2012) and maternal mortality rates are from that publication; emergency obstetric care facility estimates were calculated from UNICEF, *Tracking Progress in Maternal, Newborn and Child Survival: The 2008 Report* and A. Paxton and others, "Global patterns in availability of emergency obstetric care", *International Journal of Gynaecology and Obstetrics*, vol. 93 (2006) using national crude birth rates from UNdata (http://data.un.org). Benchmark of five EmOC facilities per 20,000 births represented by the vertical line.

400. Figure 36 highlights the relationships between maternal mortality and density of emergency obstetric care facilities when measured per 20,000 births. The authors of the analysis advocate for the value of this measure of emergency obstetric care facility density.

401. While emergency obstetric care is unavailable for many women, caesarean sections that are possibly medically unnecessary appear to command a disproportionate share of global economic resources and an "excess" number of caesarean sections have important negative implications for health equity, both within and across countries. A study undertaken by WHO on the number of caesarean sections performed in 137 countries, accounting for approximately 95 per cent of global births for that year, found that a total of 54 countries showed underuse of caesarean sections (rates below 10 per cent of deliveries), whereas 69 countries showed overuse (rates above 15 per cent), with the rest of the countries falling in

between. The study estimated that in 2008, over 3.1 million additional caesarean sections were needed, while at the same time 6.2 million unnecessary caesarean sections had been performed. The cost of the global "excess" caesarean sections was estimated to amount to approximately US$ 2.3 billion in health-care costs, while the cost of the global "needed" caesarean sections was approximately US$ 432 million.[294]

402. Where emergency obstetric care facilities are available, sociocultural factors, geographic and financial accessibility of care and quality of service issues continue to act as barriers to emergency obstetric care.[292] The uneven distribution of emergency obstetric care facilities between rural and urban areas exacerbates disparities experienced by rural women, who are more likely to give birth at home and have long distances and poor roads to travel should complications occur.[295] Data on the proportion of women with access to services for the management of post-partum haemorrhage in 2005 highlight these disparities in access between rural and urban women (see figures 37 to 39) and the high variability between countries.[296]

403. These persistent barriers and gaps in coverage illustrate the investments needed to realize the life-saving reproductive health care for women in many developing countries in order to bring skilled care and emergency obstetric services to women in need.

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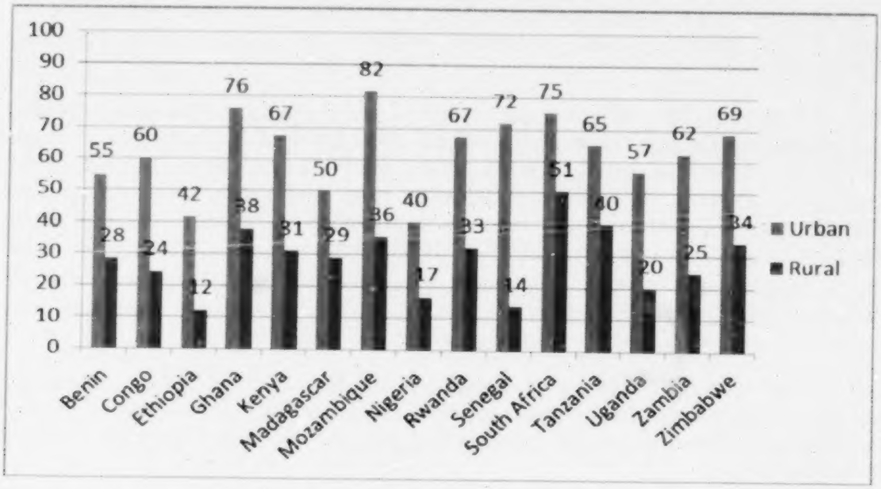
[294] L. Gibbons and others, "The global numbers and costs of additionally needed and unnecessary Caesarean sections performed per year: overuse as a barrier to universal coverage", background paper No. 30, prepared for *The World Health Report* (World Health Organization, 2010).

[295] UNFPA, "Urgent response: providing emergency obstetric and newborn care"; available from www.unfpa.org/webdav/site/global/shared/factsheets/srh/EN-SRH%20fact%20sheet-Urgent.pdf.

[296] MNPI (Maternal and Neonatal Program Effort Index) is a metric developed by the Futures Group International, providing data from about 50 developing countries on 81 maternal and neonatal health service indicators in order to comparatively assess aspects of maternal and neonatal health services, including the capacity of health centres and district hospitals to provide maternal health services; access to services in rural and urban areas; maternal and neonatal health care received; family planning provision; and policy and support services.

Figure 37

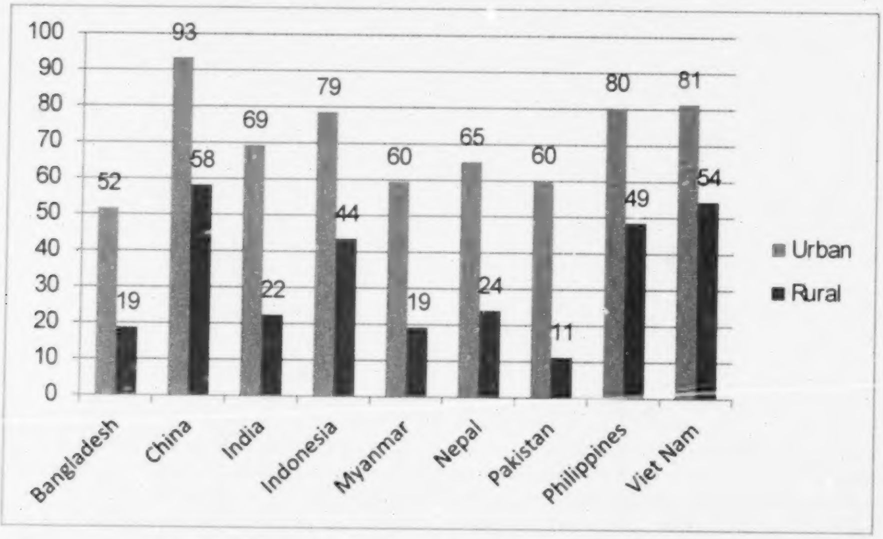
Estimated coverage of women with access to management of post-partum haemorrhage, urban-rural, selected African countries, 2005



Source: Analysis based on data from the Maternal and Neonatal Program Effort Index, available from www.policyproject.com/pubs/mnpi/getmnpi.cfm.

Figure 38

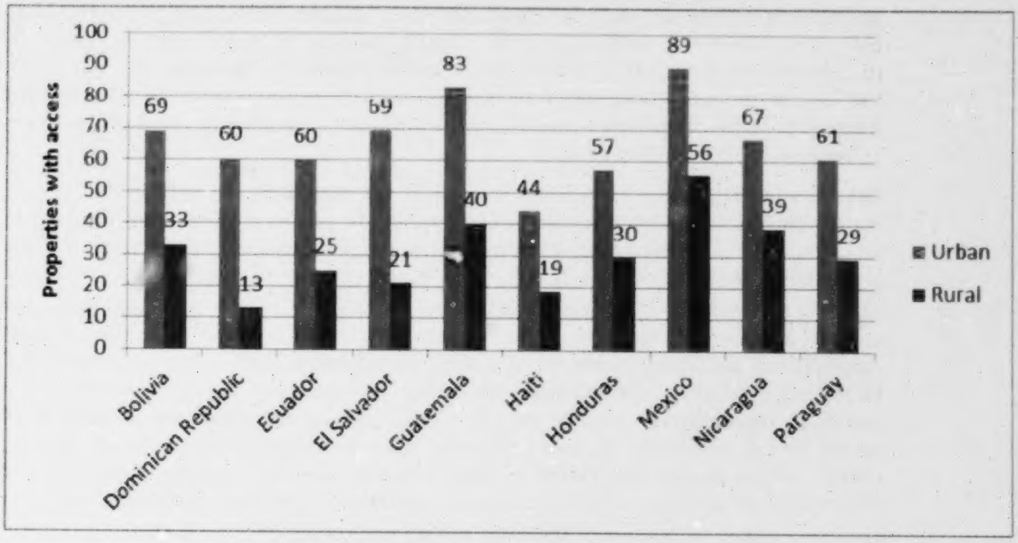
Estimated coverage of women with access to management of post-partum haemorrhage, urban-rural, selected Asian countries, 2005



Source: Analysis based on data from the Maternal and Neonatal Program Effort Index, available from www.policyproject.com/pubs/mnpi/getmnpi.cfm.

Figure 39

Estimated coverage of women with access to management of post-partum haemorrhage, urban-rural, selected Latin American and Caribbean countries, 2005



Source: Analysis based on data from the Maternal and Neonatal Program Effort Index, available from www.policyproject.com/pubs/mnpi/getmnpi.cfm.

404. Although 79 per cent of countries reported in the global survey that they had addressed the issue of providing "referrals to essential and comprehensive emergency obstetric care", the percentage of countries that reported having an adequate geographic distribution of emergency obstetric care facilities ranged from 40 per cent in Africa to 97 per cent in Europe. Hence, actions fell short where health systems were most fragile, and where the numbers of skilled personnel were inadequate and poorly distributed in countries.

405. Distribution of health-care services is strongly associated with maternal mortality ratios, in that 96 per cent of countries with the lowest maternal mortality ratios reported having an adequate geographic distribution of emergency obstetric care facilities in the global survey, but this drops to 29 per cent in the case of countries with the highest maternal mortality ratios.

6. Sexually transmitted infections

406. New cases of sexually transmitted infections appear to have increased significantly since 1994, driven in part by population growth among young people in areas of high incidence, including the Americas and sub-Saharan Africa. The

highest rates of sexually transmitted infections are generally found among urban men and women between 15 and 35 years, the ages of greatest sexual activity.[297]

407. In 1995, WHO estimated that there were 333 million cases of the four major curable sexually transmitted infections among 15- to 49-year-olds: syphilis, gonorrhoea, chlamydia and trichomoniasis. By 2008, this figure had grown to nearly half a billion (499 million) cases, largely due to a major rise in cases of trichomoniasis, from 167 million to 276.4 million cases (an increase of 65 per cent), and a rise in gonorrhoea from 62 million to 106 million cases (a 71 per cent increase). These increases coincided with a 12 per cent decline in syphilis, from 12 million to 10.6 million cases.[297]

408. While the decline in syphilis is notable, the remaining 10 million cases are a major reproductive health burden: when syphilis in pregnant women (it occurred in an estimated 1.3 million pregnancies in 2008) is left untreated, 21 per cent of those pregnancies will result in stillbirth and 9 per cent in neonatal death.[298] Many sexually transmitted infections contribute to infertility in both women and men, and untreated gonorrhoea and chlamydia in pregnant women can lead to severe neonatal morbidities, including blindness. Further, co-infection with sexually transmitted infections (including gonorrhoea, chlamydia, syphilis, and herpes simplex virus) increases susceptibility to HIV infection and likewise increases the infectivity of people living with HIV. Human papilloma virus is the principal cause of cervical cancer, which causes the deaths of approximately 266,000 women annually, over 85 per cent of whom live in resource-poor countries.[299] Human papilloma virus has also been linked to cancers of the anus, mouth and throat.[300]

409. Not all post-1994 investments to address sexual and reproductive health needs have been successful. Low-cost diagnostic interventions for sexually transmitted infections among women were a widely promoted intervention that yielded limited success, other than for syphilis. Widespread promotion of syndromic algorithms to diagnose sexually transmitted infections among women with vaginal discharge has not proven reliable and instead led to overtreatment; these methods have been far more successful with men.[301] Overall, because sexually transmitted infections are more symptomatic in men, diagnostic screening and treatment for males is a more

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[297] WHO, "Global prevalence and incidence of selected curable sexually transmitted infections: overview and estimates", document WHO/HIV_AIDS/2001.02; WHO, *Prevalence and Incidence of Selected Sexually Transmitted Infections:* Chlamydia trachomatis, Neisseria gonorrhoeae, *syphilis and* Trichomonas vaginalis — *Methods and Results used by WHO to Generate 2005 Estimates* (Geneva, 2011).

[298] WHO, *Prevalence and Incidence of Selected Sexually Transmitted Infections.*

[299] GAVI Alliance, Human Papillomavirus factsheet; available from www.gavialliance.org/library/publications/gavi-fact-sheets/factsheet--hpv-(human-papillomavirus).

[300] See Centers for Disease Control and Prevention (www.cdc.gov/hpv/cancer.html) (accessed 20 December 2013).

[301] WHO, "Sexually transmitted infections", Factsheet No. 110 (November 2013); available from www.who.int/mediacentre/factsheets/fs110/en; R. Snow and K. P. Bista, "International consultative workshop on STI case management in South Asia, Kathmandu, Nepal, July 2001", meeting report (National Centre for AIDS and STD Control of Nepal and University of Heidelberg STI/HIV Control Project).

cost-effective means of controlling sexually transmitted infections and warrants further investment.[302]

410. Polymerase chain reaction technologies have vastly improved sexually transmitted infection diagnostics of, but their expense limits widespread use. Inexpensive and accurate rapid diagnostic tests would be helpful in low resource settings, but rapid diagnostic tests for syphilis are not yet widely available and a test for chlamydia is still under development.[303] Well-equipped laboratory systems are a critical component of referral-level health systems, valuable for sexually transmitted infections and a range of other conditions, and warrant further investment. The human papilloma virus vaccine has proven highly effective and offers considerable promise for curtailing certain strains of the virus.

411. WHO undertakes global efforts to aggregate the best available reporting of data on sexually transmitted infections from countries, but the data reflect widespread weaknesses in surveillance outside select wealthy countries, and therefore global summary data must be interpreted cautiously.

412. In two recent reviews[304] WHO emphasized the poor quality and limited coverage of data on sexually transmitted infections. There are no sentinel surveillance systems for collecting data on sexually transmitted infections globally. Data on syphilis and, to a lesser extent, drug-resistant gonorrhoea are collected through the Global AIDS Response Progress Reporting, a collaborative effort of WHO, UNAIDS and UNICEF. Figure 40 depicts both the paucity of available data on sexually transmitted infection screening of pregnant women, a necessary first step for sexually transmitted infection case identification and management, and, where data are available, these highlight the low levels of screening at first antenatal visit across several countries in Africa, South America, the Middle East and parts of China. This may be reflective of insufficient sexual and reproductive health services in some of these regions; it is worthwhile to note that countries in North America and Europe have separate and more sophisticated surveillance systems which are not reflected.

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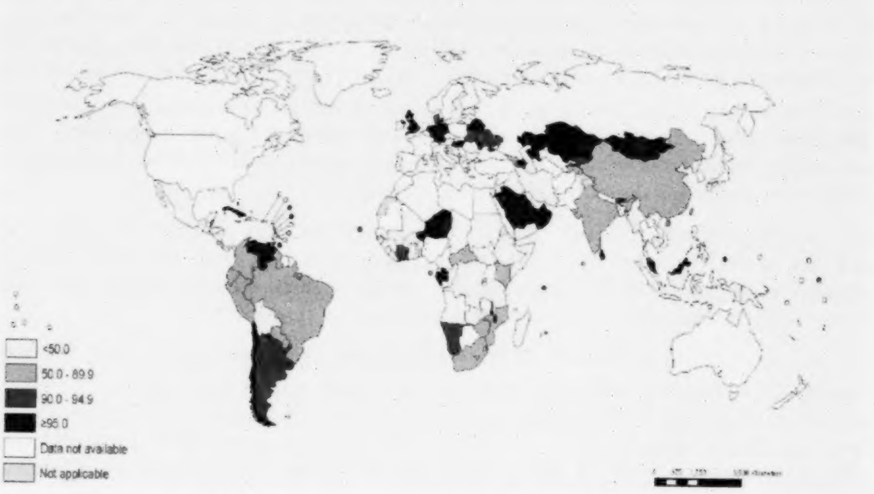
[302] K. L. Dehne, R. Snow and K. R. O'Reilly, "Integration of prevention and care of sexually transmitted infections with family planning services: what is the evidence for public health benefits?", *Bulletin of the World Health Organization*, vol. 78, No. 5 (2000).

[303] WHO, *Global Strategy for the Prevention and Control of Sexually Transmitted Infections: 2006-2015 — Breaking the Chain of Transmission* (Geneva, 2007); WHO, "Sexually transmitted infections", Factsheet No. 110 (November 2013).

[304] WHO, *Baseline Report on Global Sexually Transmitted Infection Surveillance 2012* (Geneva, 2013); available from http://apps.who.int/iris/bitstream/10665/85376/1/9789241505895_eng.pdf.

Figure 40

Percentage of antenatal care attendees tested for syphilis at first visit, latest available data since 2005



Source: WHO, Global Health Observatory map gallery, available from www.who.int/gho/map_gallery/en/index.html.

413. In the light of current needs, WHO and its partner agencies are calling for a much-needed concerted global effort to build systematic surveillance for sexually transmitted infections, including screening and effective case management. Urgent implementation of this proposal is necessary if we are to strengthen public health systems with improved data for estimations of sexually transmitted infection, and ultimately control the spread of sexually transmitted infections and limit the resultant morbidities.[305]

414. **States and global health partners should commit to strengthening national and global surveillance of the incidence and prevalence of sexually transmitted infections, support the development and widespread use of accurate and affordable diagnostic tests for sexually transmitted infections, and promote greater access to quality diagnosis and treatment of sexually transmitted infections, including for men and boys.**

7. Prevention of HIV

415. New HIV infections have declined globally by 33 per cent, from a high of 3.4 million per year in 2001 to 2.3 million in 2012. In 26 low- and middle-income countries new HIV infections decreased by more than 50 per cent between 2001 and 2012. New HIV infections among adults in sub-Saharan Africa, where 70 per cent of all new infections occur, have decreased by 34 per cent since 2001. However, the number of new infections has risen in Eastern Europe and Central Asia in recent

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[305] WHO, "Sexually transmitted infections (STIs)", document WHO/RHR/13.02; available from http://apps.who.int/iris/bitstream/10665/82207/1/WHO_RHR_13.02_eng.pdf.

years, despite declines in Ukraine, and new infections continue to rise in the Middle East and North Africa.[306]

416. Declines in the rates of new HIV infections among adults largely reflect a reduction in sexual transmission. However, regional achievements in HIV prevention mask critical disparities within and between countries. For example, throughout Southern Africa, new HIV infections are occurring despite widespread knowledge about the disease and good access to condoms. In South Africa, the country with the highest absolute number of people living with HIV, the annual number of new infections declined rapidly after peaking in 1998, but the pace of decline slowed between 2004 and 2011, and HIV incidence remains high even after a substantial decline from 2011 to 2012.[307]

417. While "people who inject drugs account for an estimated 0.2-0.5 per cent of the world's population, they make up approximately 5-10 per cent of all those living with HIV".[306] Preventing HIV among people who inject drugs and their sexual partners is a key priority in Eastern Europe and Central Asia, where people who inject drugs account for more than 40 per cent of new infections in some countries. In countries where the incidence of HIV is closely related to intravenous drug use, Governments have yet to show a strong political commitment to address the problem and lack adequate data systems for monitoring the epidemic.[306]

418. Globally, female, male and transgender sex workers are at a higher risk of contracting HIV, with female sex workers 13.5 times more likely to be living with HIV compared with other women. Yet funding for HIV prevention among sex workers remains disproportionately low, given the level of their risk. Men who have sex with men are also at increased risk of contracting HIV, accounting for a disproportionate number of new infections in the Americas and Asia; among men who have sex with men, the young and homeless are at greatest risk. Sex workers, men who have sex with men and other key populations at higher risk of contracting HIV continue to face stigma, discrimination and, in many cases, punitive laws that compound vulnerabilities and serve as a barrier to critical prevention, treatment, care and support efforts.[306]

419. Ninety-two per cent of Governments participating in the global survey reported having addressed the issue of "increasing access to [sexually transmitted infection]/ HIV prevention, treatment and care services for vulnerable population groups and populations at risk" in the previous five years, but with varying degrees of success.

420. Preventing new HIV infections depends to a considerable extent on behavioural change. The effectiveness of approaches to bringing about such change has differed from region to region. In several countries across Africa, sexually risky behaviours increased from 2000 to 2012, with evidence of significant increases in the number of sexual partners (in Burkina Faso, the Congo, Côte d'Ivoire, Ethiopia, Gabon, Guyana, Rwanda, South Africa, Uganda, the United Republic of Tanzania and Zimbabwe), and declines in condom use (in Côte d'Ivoire, the Niger, Senegal and Uganda).[306] Understanding and addressing the persistence of sexual risk-taking in the face of widespread knowledge about and access to condoms and its links to gender norms and structural inequality is a major public health challenge for the coming decade.

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[306] UNAIDS, *Global Report: UNAIDS Report on the Global AIDS Epidemic 2013* (see footnote 16 above).

[307] UNAIDS, AIDSinfo Online Database (www.aidsinfoonline.org/devinfo/libraries/aspx/Home.aspx).

421. There is the need for a major United Nations meeting of Governments, experts and civil society organizations to address this uneven success, the failure of behaviour change in some parts of the world, and the evidence that preventive behaviour is declining in many high-risk countries.

422. **States and global health partners should address the stark disparities in the success of HIV prevention in different parts of the world, and among different population groups; undertake research to understand the underlying causes of such disparities; and share proven policy lessons to reduce HIV infections in high-incidence populations.**

Human rights elaborations since the International Conference on Population and Development

Box 18
HIV and AIDS

Intergovernmental human rights outcomes. Since 1994 there have been considerable elaborations of human rights protections as they relate to persons living with HIV and AIDS. The General Assembly has adopted three declarations on HIV and AIDS, including the Political Declaration on HIV and AIDS: Intensifying our Efforts to Eliminate HIV/AIDS, annexed to resolution 65/277 (2011), in which the Assembly reaffirmed "that the full realization of all human rights and fundamental freedoms for all is an essential element in the global response to the HIV epidemic". The Commission on Human Rights adopted a series of resolutions on protecting the human rights of persons living with HIV, including resolution 2005/84 on the protection of human rights in the context of human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) (2005).

Other soft law. In 1997, the International Guidelines on HIV/AIDS and Human Rights presented a framework for promoting the rights of persons living with HIV and AIDS. Since the International Conference on Population and Development, human rights treaty bodies have increasingly addressed the rights of people living with HIV, including in general comments and concluding observations. Treaty bodies have established that States must guarantee people living with HIV equal enjoyment of their human rights,[308] and that antiretroviral therapy should be available, affordable, and accessible,[309] and that States must take action to eradicate barriers to access.[310] Appropriate resources must be allocated to HIV and AIDS programmes,[311] and monitored for effectiveness.[312] States are also urged to take action to counter stigma and discrimination related to HIV and AIDS.[313] States should ensure that people living with HIV can make informed and voluntary decisions about reproduction.[314] Treaty monitoring bodies have also advised States to address certain populations such as young women, people in rural areas, ethnic minority groups, older persons, and other groups facing vulnerabilities.[315]

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[308] Concluding observations of the Committee on the Elimination of Discrimination against Women following the consideration by the Committee of the combined initial, second and third periodic report of Ethiopia (A/51/38), chap. IV, sect. B.2, para. 161.

[309] Committee on Economic, Social and Cultural Rights, general comment No. 14 (2000) on the right to the highest attainable standard of physical and mental health (article 12 of the International Covenant on Economic, Social and Cultural Rights) (E/2001/22, annex IV); concluding observations of the Committee on Economic, Social and Cultural Rights following the consideration by the Committee of the fourth periodic report of the United Kingdom of Great Britain and Northern Ireland, the Crown Dependencies and the Overseas Dependent Territories (E/C.12/1/Add.79, para. 40); concluding observations of the Human Rights Committee following the consideration by the Committee of the second periodic report of Kenya (CCPR/CO/83/KEN, para. 15).

8. HIV and AIDS-related treatment, care and support

423. What was soon to become an HIV pandemic had not fully emerged at the time of the International Conference on Population and Development in 1994. In 1993, an estimated 14 million people were living with HIV, but it was only after the Conference that the pandemic exploded. Within a decade (2003), an estimated 31.7 million people were living with HIV, with three quarters of them residing in Africa.[316] The response of Governments and aid institutions followed, but not before deaths from AIDS had reached a peak of 2.3 million per year in 2005.[306] In terms of the global burden of disease, HIV rose from the thirty-third largest cause of disability-adjusted life years lost in 1990 to the fifth largest in 2010. And while deaths due to AIDS have declined sharply, for an estimated 1.6 million people in 2012,[306] AIDS remains the leading cause of death in women of reproductive age (15-49 years)

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[310] Concluding observations of the Committee on Economic, Social and Cultural Rights following the consideration by the Committee of the initial report of Honduras (E/C.12/1/Add.57, paras. 26 and 47); and the initial report of Zambia (E/C.12/1/Add.106, para. 30).

[311] Committee on the Rights of the Child, general comment No. 3 (2003) on HIV/AIDS and the rights of the child (see A/59/41, annex IX).

[312] Concluding observations of the Committee on the Rights of the Child following the consideration by the Committee of the initial report of Zambia (CRC/C/15/Add.206, para. 51 (d)).

[313] Concluding observations of the Committee on the Rights of the Child following the consideration by the Committee of the second periodic report of Bhutan (CRC/C/BTN/CO/2, para. 59 (d)); and the consolidated second and third periodic report of Kazakhstan (CRC/C/KAZ/CO/3, para. 54 (d)).

[314] Committee on the Elimination of Discrimination against Women, general recommendation 24 concerning article 12 of the Convention on the Elimination of All Forms of Discrimination against Women on women and health, adopted by the Committee at its twentieth session (see A/54/38/Rev.1, part one, chap. I, sect. A).

[315] Concluding observations of the Committee on the Elimination of Discrimination against Women following the consideration by the Committee of the combined second and third periodic report of the Republic of Moldova (CEDAW/C/MDA/CO/3, para. 31); and the initial report of Myanmar (A/55/38, chap. IV, sect. B, para. 96); concluding observations of the Human Rights Committee following the consideration by the Committee of the second periodic report of Lithuania (CCPR/CO/80/LTU, para. 12); concluding observations of the Committee on Economic, Social and Cultural Rights following the consideration by the Committee of the initial report of China (including Hong Kong and Macao) (E/C.12/1/Add.107, para. 60); concluding observations of the Committee on the Elimination of Discrimination against Women following the consideration by the Committee of the combined fifth and sixth periodic report of Zambia (CEDAW/C/ZMB/CO/5-6, para. 36 (a)); and the combined fourth to seventh report of Uganda (CEDAW/C/UGA/CO/7, para. 46).

[316] UNAIDS, AIDSInfo Online Database (www.aidsinfoonline.org/devinfo/libraries/aspx/Home.aspx). Data downloaded 5 December 2013.

worldwide.[317] In sub-Saharan Africa, deaths due to AIDS and those resulting from maternity-related causes are leading causes of death in women of reproductive age.[318]

424. Under the newly revised (2013) WHO treatment guidelines, the 9.7 million people receiving antiretroviral therapy in 2012 represented only 34 per cent of persons eligible for treatment.[306] Changes in treatment guidelines were made in response to new evidence on the benefits of beginning antiretroviral therapy earlier in the natural history of HIV infection. Consequently, despite expanding access to antiretroviral therapy, the proportion of eligible persons receiving it falls far short of the Millennium Development Goal 6 target of universal access to antiretroviral therapy by 2015.[306] While treatment programmes have been successfully rolled out in many countries, delivery remains challenging where health systems are weak and understaffed, and stigma creates obstacles to testing and care. Notably, antiretroviral therapy coverage reached fewer children eligible for treatment than adults globally, and scale-up continues to favour adults.[306]

425. The percentage of pregnant women living with HIV who have access to antiretroviral therapy has risen dramatically owing to the sustained scale-up of vertical transmission programmes, with coverage reaching 63 per cent globally in 2012. There is, however, considerable variation in the coverage of prevention of mother-to-child transmission of HIV programmes between regions, with coverage exceeding 90 per cent in Eastern and Central Europe and the Caribbean, while remaining at less than 20 per cent in the Pacific, the Middle East and North Africa. Among countries with generalized epidemics, 13 countries provided antiretroviral therapy to less than 50 per cent of pregnant women living with HIV, while 13 countries reached prevention of mother-to-child transmission coverage levels of 80 per cent.[306] Differentials in prevention of mother-to-child transmission coverage among countries with a generalized epidemic do not appear to reflect differences in underlying national HIV prevalence.[319]

426. While prevention of mother-to-child transmission has increased access to treatment among pregnant women, pregnant women still receive antiretroviral therapy for their own health at lower levels than the general population.[306] Additionally, sex differentials persist in access to and use of HIV testing and counselling services,[320] as well as treatment.[321] Gains in prevention of mother-to-child transmission coverage

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[317] WHO, "Women's health", Factsheet No. 334 (September 2013); available from www.who.int/mediacentre/factsheets/fs334/en/.

[318] WHO and others, *Trends in Maternal Mortality* (see footnote 278 above).

[319] UNAIDS, AIDSInfo Online Database; available from www.aidsinfoonline.org/devinfo/libraries/aspx/Home.aspx.

[320] P. Glick and D. Sahn, "Changes in HIV/AIDS knowledge and testing behavior in Africa: how much and for whom?", *Journal of Population and Economics*, vol. 20, No. 2 (2007), pp. 383-422; S. Mitchell and others, "Equity in HIV testing: evidence from a cross-sectional study in ten Southern African countries", *BMC International Health and Human Rights*, vol. 10, No. 23 (2010); R. C. Snow, M. Madalane and M. Poulsen, "Are men testing? Sex differentials in HIV testing in Mpumalanga Province, South Africa", *AIDS Care*, vol. 22, No. 9 (2010), pp. 1060-1065; A. E. Yawson, P. Dako-Gyeke and R. Snow, "Sex differences in HIV testing in Ghana, and policy implications", *AIDS Care*, vol. 24, No. 9 (2012), pp. 1181-1185.

[321] P. Braitstein and others, "Gender and the use of antiretroviral treatment in resource-constrained settings: findings from a multicenter collaboration", *Journal of Women's Health*, vol. 17, No. 1 (2008), pp. 47-55; P. Dako-Gyeke, R. Snow and A. E. Yawson, "Who is utilizing anti-retroviral therapy in Ghana: an analysis of ART service utilization", *International Journal for Equity in Health*, vol. 11, No. 62 (2012); A. S. Muula and others, "Gender distribution of adult patients on highly active antiretroviral therapy (HAART) in Southern Africa: a systematic review", *BMC Public Health*, vol. 7, April 2007.

have translated into decreased transmission of HIV from mothers to their children, preventing more than 670,000 children from acquiring HIV. In 2012, 260,000 children were newly infected in low- and middle-income countries, representing a 35 per cent decline since 2009.

427. **States should ensure universal access to HIV information, education and counselling services, including voluntary and confidential HIV testing, with a particular focus on young persons and persons with increased risk of HIV; and commit to providing, in the shortest time possible, universal access to antiretroviral therapy with the aims of eliminating mother-to-child transmission of HIV, ensuring follow-up of infants exposed to HIV, improving the life expectancy and quality of life of mothers and all people living with AIDS, and protecting all people living with HIV from stigma, discrimination and violence.**

428. Regarding the "eliminating mother-to-child transmission of HIV and treatment for improving the life expectancy of HIV-positive mothers", the global survey shows that 86 per cent of countries reported addressing this issue during the previous five years; among the 38 countries that UNAIDS identifies as suffering from a "high impact" of HIV and AIDS, 97 per cent reported addressing this issue during the same time period. Although goals are not yet met, this indicates a greater concentration of efforts in the countries of greatest need.

E. Non-communicable diseases

429. Since the International Conference on Population and Development, the contribution of non-communicable diseases to the burden of disease in the developing world has become far more prominent. There was a 30 per cent increase in the number of deaths related to non-communicable diseases (most significantly, cardiovascular diseases, cancers, chronic respiratory diseases and diabetes) globally between 1990 and 2010[322] In all regions except Africa, deaths from non-communicable diseases exceed those caused by maternal, perinatal, communicable and nutritional disorders combined.[323] The mortality rates from non-communicable diseases are higher in the more developed regions, especially Eastern Europe, where older persons represent a higher proportion of the population. However, age-standardized death rates from non-communicable diseases show that people living in Africa have the highest risk of death due to non-communicable diseases than in any other region.[324] Deaths from non-communicable causes are expected to increase by 44 per cent between 2008 and 2030 worldwide, with the burden of disease highest among low- and middle-income countries where population growth rates are higher and longevity is increasing.[323]

430. About half of all non-communicable diseases can be attributed to high blood pressure (13 per cent of global deaths), tobacco use (9-10 per cent), elevated cholesterol and glucose (6 per cent), physical inactivity (6-7 per cent) and obesity

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[322] R. Lozano and others, "Global and regional mortality from 235 causes of death for 20 age groups in 1990 and 2010: a systematic analysis for the Global Burden of Disease Study 2010", *The Lancet*, vol. 380, No. 9859 (15 December 2012), pp. 2095-2128.

[323] WHO, *Global Status Report on Noncommunicable Diseases 2010* (Geneva, 2011).

[324] United Nations, "Population ageing and the non-communicable diseases" Population Facts, No. 2012/1.

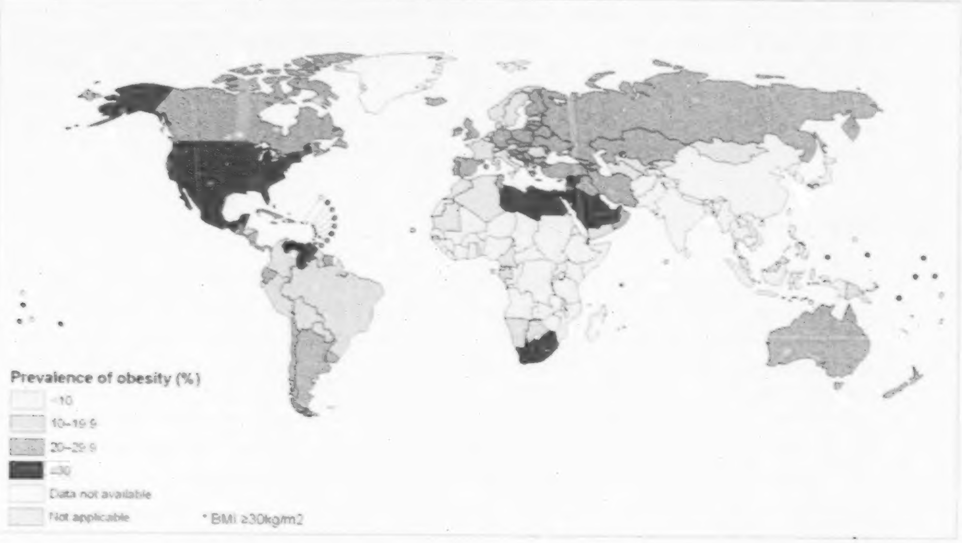
(5-7 per cent).[325] It is therefore important to reach young people early in life by educating adolescents, youth and parents about the importance of a healthy diet and exercise, and the risks of harmful alcohol use and smoking.

1. Non-communicable diseases and inequity

431. While behaviours and risk factors related to non-communicable diseases are commonly associated with those living in higher-income countries, a "globalization of unhealthy lifestyles" is taking place.[326] For example, the worldwide prevalence of obesity almost doubled between 1980 and 2008, and is high in countries from both developed and less developed regions (see figure 41).

Figure 41

Prevalence of obesity, ages 20 and over, age standardized, both sexes, 2008



Source: WHO, Global Health Observatory map gallery, available from www.who.int/gho/map_gallery/en/index.html (accessed 25 October 2013).

432. In all regions, women are more likely to be obese than men.[327] Obesity among young children has increased in all regions, but is rising most rapidly in low- and middle-income countries, where it is projected to double by 2015 from its level in 1990.[328] The poor may be predisposed to non-communicable diseases from such factors as low weight at birth, poor nutrition during childhood and exposure to second-hand smoke. Non-communicable diseases are largely chronic diseases that

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[325] S. Sawyer and others, "Adolescence: a foundation for future health", *The Lancet*, vol. 379, No. 9826 (2012), pp. 1630-1640; WHO, *Global Status Report on Noncommunicable Diseases 2010*.

[326] D. Bloom and others, *The Global Economic Burden of Non-communicable Diseases* (Geneva, World Economic Forum, 2011).

[327] WHO, *World Health Statistics 2012* (Geneva, 2012).

[328] WHO, *Global Status Report on Noncommunicable Diseases 2010*, p. 24.

affect work attendance, remove people from the labour force and take an economic toll in terms of lost economic productivity as well as health-care costs.

433. In the developing world, illness and deaths from non-communicable diseases are occurring at earlier ages and affecting adults in their prime income-generating years.[329] A much greater proportion of deaths related to non-communicable diseases occur among people younger than 60 years of age in low- and middle-income countries (29 per cent) compared with high-income countries (13 per cent), and the poor are more likely to die prematurely than those who are better off.[323]

2. Mental illness

434. Mental illness is a key non-communicable disease affecting hundreds of millions of people globally, and is the leading cause of disability-adjusted life years lost from non-communicable diseases.[326] Depressive disorders account for about a third of this toll, affecting 154 million people globally, and are measurably more common among women, especially young women. According to Alzheimer's Disease International, 44 million people currently live with the disease, a number that will grow to 135 million by 2050. In addition, by 2050, 71 per cent of the cases will be in low- and middle-income countries.[330]

435. Mental illness and poverty are mutually reinforcing: the conditions of poverty increase exposure to stress, malnutrition, violence and social exclusion, while mental illness increases the likelihood of becoming or remaining poor.[331] Mental health conditions, along with cardiovascular diseases, account for 70 per cent of lost economic output, and the global economic burden of non-communicable diseases is expected to double between 2010 and 2030.[326] Although the highest economic toll will occur in high-income countries, improving mental health in low- and middle-income countries should be a development priority.[332]

3. Preventing non-communicable diseases: start in adolescence

436. Most non-communicable diseases, and about 70 per cent of premature deaths among adults, are strongly associated with four behaviours that begin or are reinforced in adolescence: smoking, harmful alcohol use, inactivity and overeating or poor nutrition.[333] For example, smoking is typically begun in adolescence and is responsible for one in six deaths related to non-communicable diseases.[334] Reducing both the supply and the demand for tobacco would avert an estimated 5.5 million deaths over 10 years in 23 low- and middle-income countries with a high burden of non-communicable diseases.[334] Furthermore, evidence from Europe and

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[329] W. Baldwin and L. Amato, "Global burden of noncommunicable diseases", Factsheet (Washington, D.C., Population Reference Bureau, July 2012).

[330] Alzheimer's Disease International, "Policy brief for Heads of Government: the global impact of dementia 2013-2050" (London, December 2013); available from www.alz.co.uk/research/G8-policy-brief.

[331] C. Lund and others, "Poverty and mental disorders: breaking the cycle in low-income and middle-income countries", *The Lancet*, vol. 378, No. 9801 (2011), pp. 1502-1514.

[332] "Mental health care: the economic imperative", *The Lancet*, vol. 378, No. 9801 (2011), p. 1440.

[333] M. D. Resnick and others, "Seizing the opportunities of adolescent health", *The Lancet*, vol. 376, No. 9826 (2012), pp. 1564-1567.

[334] R. Beaglehole and others, "Priority actions for the non-communicable disease crisis", *The Lancet*, vol. 377, No. 9775 (2011), pp. 1438-1447.

low- and middle-income countries suggest that there is rising alcohol consumption among youth, beginning at a young age.[335]

437. Lifelong health education should begin with young people, both within the school curricula and in concert with comprehensive sexuality education, as many life habits relating to long-term health are initiated and formed at young ages and are intertwined with aspects of identity formation and aspirations for adulthood.

438. States should reduce risk factors for non-communicable diseases through the promotion of healthy behaviours among children and adolescents through school programmes, public media, and within comprehensive sexuality education, including skills to resist tobacco use and other substance abuse, healthy eating and nutrition, movement and exercise, and stress management and mental health care.

F. Changing patterns of life expectancy

439. At the global level, life expectancy at birth for both sexes increased from 64.8 years from 1990 to 1995 to 70 years in the period 2010-2015, a gain of 5.2 years, reflecting changes in female life expectancy at birth from 67.1 to 72.3 years and in male life expectancy from 62.5 to 67.8 years over the same period.[336]

440. All regions of the world experienced gains in life expectancy, and progress has been steady in almost all of them except Africa and Europe. In Africa, life expectancy had a slow increase in the 1990s, as mortality in a number of countries soared owing to HIV/AIDS and conflict, but regained momentum in the 2000s. As a result, in the last two decades Africa gained 6.5 years in life expectancy. Similarly, in Europe, the increase in life expectancy in the 1990s was slow, owing to rising mortality in a number of successor States of the former Soviet Union, but it also accelerated again in the 2000s. Currently, sub-Saharan Africa has the lowest life expectancy, 56 years, 14 years less than the world average. In fact, all the countries of the world with a life expectancy lower than 60 years (a total of 30 countries) are in Africa, including six with levels below 50 years: Sierra Leone, Botswana, Swaziland, Lesotho, the Democratic Republic of the Congo and the Central African Republic.[336]

441. While aggregate analysis highlights the well-known view that women, on average, live longer than men, national, subnational and trend analyses show that this pattern is hardly fixed, as the extent of the gender gap varies significantly between populations and has been changing over time.[337] Countries at early stages of their demographic and epidemiological transitions have life expectancy differentials favouring women by approximately 2-3 years. In these contexts, unclean water, infections, inadequate nutrition, lack of access to health care and other structural conditions cause high mortality across all age groups, in particular during childhood. These same conditions make women vulnerable during pregnancy and childbirth and drive higher rates of fertility as a means of protection against high infant and child mortality, which in turn increase women's lifetime maternal mortality risk.[337]

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[335] R. Beaglehole and others, "Measuring progress on the NCDs: one goal and five targets", *The Lancet*, vol. 380, No. 9850 (2012), pp. 1283-1285.

[336] *World Population Prospects: The 2012 Revision* (ST/ESA/SER.A/336).

[337] A. T. Geronimus and R. C. Snow, "The mutability of women's health with age: the sometimes rapid and often enduring, health consequences of injustice", in *Women and Health*, 2nd ed., M. B. Goldman, R. Troisi and K. M. Rexrode, eds. (London, Academic Press, 2013).

442. The growing HIV epidemic reversed gains in life expectancy seen in many African countries in the 1970s,[338] with a greater impact on women. This is due in part to women's higher AIDS-related mortality, which reflects women's higher risk of contracting HIV sexually because of greater biological risk, as well as disempowerment in sexual relationships.[339] In certain countries in Africa men currently have greater life expectancy than women.[337]

443. Women have a marked advantage over men in life expectancy (10 years or more) in former Soviet republics, reinforced as male life expectancy declined in the late 1980s and the beginning of the 1990s.[340] Life expectancy among males increased marginally, but has since stagnated. The causes of men's decline in life expectancy are debatable, but are attributed, in part, to increased stress, heart disease, and alcohol-related causes of death associated with political turmoil. These changes in life expectancy illustrate the influence of social and political context on health and longevity.[337]

444. In high-income, industrialized countries women have a higher life expectancy (4-7 years) than men. These gender differentials peaked in the 1970s, owing largely to men's high rates of smoking in the preceding decades. The contraction of the gender gap seen in recent years is attributed, in part, to the decrease in smoking among males over the past 20 years.[341]

445. Inequalities in life expectancy are dynamic — they change over time — both within and between populations, reflecting variable political, economic and epidemiological contexts. Because a central obligation of States is to respect, promote and protect the human rights of its people, life expectancy is an aggregate indicator of the extent to which States fulfil this obligation, and invest adequately in the capabilities, health, social protection and resilience of its citizens.

G. Unfinished agenda of health system strengthening

446. Despite decades of unprecedented medical advances and innovations in health care, stark inequalities in the accessibility and quality of health systems persist across and within countries. Sub-Saharan Africa and, to a lesser extent, South Asia continue to have some of the least accessible and most fragile health systems, as measured by operations indicators such as health worker density, coverage of critical services, commodity stock-outs and record keeping, or by health outcomes.

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[338] J. Adetunji and E. R. Bos, "Levels and trends in mortality in sub-Saharan Africa: an overview", in *Disease and Mortality in Sub-Saharan Africa*, 2nd ed., D. T. Jamison and others, eds. (Washington, D.C., World Bank, 2006).

[339] J. A. Higgins, S. Hoffman and S. L. Dworkin, "Rethinking gender, heterosexual men, and women's vulnerability to HIV/AIDS", *American Journal of Public Health*, vol. 100, No. 3 (2010), pp. 435-445.

[340] V. Shkolnikov, M. McKee and D. A. Leon, "Changes in life expectancy in Russia in the mid-1990s", *The Lancet*, vol. 357, No. 9260 (2001), pp. 917-921; D. A. Leon and others, "Huge variation in Russian mortality rates 1984-94: artefact, alcohol or what?", *The Lancet*, vol. 350, No. 9075 (1997), pp. 383-388.

[341] F. C. Pampel, "Cigarette use and the narrowing sex differential in mortality", *Population and Development Review*, vol. 28, No. 1 (2002), pp. 77-104; "Sex differentials in life expectancy and mortality in developed countries: an analysis by age group and causes of death from recent and historical data", *Population Bulletin of the United Nations*, No. 25 (United Nations publication, Sales No. E.88.XIII.6); Geronimus and Snow, "The mutability of women's health with age: the sometimes rapid and often enduring, health consequences of injustice".

Within selected middle- and high-income countries, pockets of weak and poor health system coverage or quality abound for selected areas or populations, such as for indigenous peoples, urban slums, the uninsured and undocumented groups.

1. Impact of HIV and AIDS on health systems

447. International aid for HIV was largely directed towards developing vertical HIV-specific programmes rather than building services into existing health systems. That approach was meant to allow for the rapid and urgently needed roll-out of HIV services while ideally causing spillover effects that would strengthen health systems more broadly. However, vertical structures that did not integrate HIV and AIDS within broader health systems have been faulted for diverting resources, crowding out other services from the health system and compromising overall health system strengthening in favour of a single-disease approach.[342] While urgent, potentially fatal health emergencies require priority action and resource mobilization, there is nevertheless a need to maximize benefits and strengthen health systems to provide long-term and far-reaching health prevention and care throughout the life course.

448. HIV and sexual and reproductive health are intimately related, with 80 per cent of HIV cases transmitted sexually and 10 per cent transmitted during pregnancy, childbirth or breastfeeding.[343] Yet in the years following the International Conference on Population and Development, funding for sexual and reproductive health remained stagnant in many countries while HIV aid increased dramatically.[344]

449. There has been much debate, but little decisive evidence, indicating whether increased funding and scale-up of HIV programmes have had spillover effects on service delivery for sexual and reproductive health care. However, a recent economic analysis used demographic and household surveys and OECD Creditor Reporting System data to investigate the impact of donor aid for HIV per capita on maternal health service provision across sub-Saharan Africa from 2003 to 2010. Comparing annual health outcomes with HIV aid disbursements from the previous year, the study showed that HIV development assistance had little impact on rates of

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[342] D. Yu and others, "Investments in HIV/AIDS programs: does it help strengthen health systems in developing countries?", *Globalization and Health*, vol. 4, No. 8 (2008); Columbia University, International Center for AIDS Care and Treatment Programs, "Leveraging HIV scale-up to strengthen health systems in Africa", report of a conference held in Bellagio, Italy, September 2008 (2009); W. M. El-Sadr and E. J. Abrams, "Scale-up of HIV care and treatment: can it transform healthcare services in resource-limited settings?", *AIDS*, vol. 21 (October 2007), pp. S65-S70; K. A. Grépin, "HIV donor funding has both boosted and curbed the delivery of different non-HIV services in sub-Saharan Africa", *Health Affairs*, vol. 31, No. 7 (2012), pp. 1406-1414; A. Buvé, S. Kalibala and J. McIntyre, "Stronger health systems for more effective HIV/AIDS prevention and care", *International Journal of Health Planning and Management*, vol. 18, No. 1 (2003), pp. S41-S51.

[343] I. Askew and M. Berer, "The contribution of sexual and reproductive health services to the fight against HIV/AIDS: a review", *Reproductive Health Matters*, vol. 11, No. 22 (2003), pp. 51-73; N. Duce and A. Nolan, "Seizing the big missed opportunity: linking HIV and maternity care services in sub-Saharan Africa", *Reproductive Health Matters*, vol 15, No. 30 (2007), pp. 190-201.

[344] Yu and others, "Investments in HIV/AIDS programs: does it help strengthen health systems in developing countries?"; J. Shiffman, "Has donor prioritization of HIV/AIDS displaced aid for other health issues?", *Health Policy and Planning*, vol. 23, No. 2 (2008), pp. 95-100; Grépin, "HIV donor funding has both boosted and curbed the delivery of different non-HIV services in sub-Saharan Africa".

maternal health service provision (mothers reporting antenatal care visits or skilled attendance at birth). However, in areas with low health worker density and low HIV prevalence, HIV funding had a stronger effect on building maternal health services, suggesting that AIDS dollars have multiplier effects on the more underresourced health systems, especially where HIV and AIDS are less acute.[345]

450. **States should implement full integration of HIV and other sexual and reproductive health services by greatly expanding access to quality services for diagnosis and treatment of sexually transmitted infections, including HIV testing; integrating HIV counselling within better sexual and reproductive health counselling for all people, including for adolescents and youth; strengthening continuity of care from pre-pregnancy, prenatal to post-natal and child health for all women and children, irrespective of HIV status; and addressing the contraceptive needs of all persons, including HIV-positive persons.**

2. Human resources for health

451. According to the latest numbers from the recent WHO and Global Health Workforce Alliance publication *A Universal Truth: No Health Without a Workforce*, the 2013 global health workforce shortfall stood at 7.2 million, a figure estimated to reach 12.9 million by 2035.[346] This is a marked increase from the 2006 estimated workforce shortfall of roughly 4.3 million workers across 57 countries facing critical shortages.[347] At that time, health worker shortfalls were most serious in 36 countries in Africa and in South-East Asia, dominated by the needs of Bangladesh, India and Indonesia (see table 2). The mix of countries identified as having low human-resource-for-health density and/or low service coverage has since changed. Of the original 57 countries facing critical shortages, 46 have available data that show increases in the numbers of physicians, nurses and midwives. However, these net gains are outpaced by population growth over time, which further exacerbates the health worker shortfalls.[346]

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[345] Grépin, "HIV donor funding has both boosted and curbed the delivery of different non-HIV services in sub-Saharan Africa".

[346] Global Health Workforce Alliance and WHO, *A Universal Truth: No Health without a Workforce, executive summary* (Geneva, World Health Organization, 2013).

[347] WHO, *The World Health Report 2006: Working Together for Health* (Geneva, 2006), chap. 1; available from www.who.int/whr/2006/whr06_en.pdf.

Table 2

Estimated critical shortages of doctors, nurses and midwives by region, 2006

	Number of countries		*In countries with shortages*		
WHO region	*Total*	*With shortages*	*Total stock*	*Estimated shortage*	*Percentage increase required*
Africa	46	36	590 198	817 992	139
Americas	35	5	93 603	37 886	40
South-East Asia	11	6	2 332 054	1 164 001	50
Europe	52	0	–	–	–
Eastern Mediterranean	21	7	312 613	306 031	98
Western Pacific	27	3	27 260	32 560	119
World	192	57	3 355 728	2 358 470	70

Source: WHO, *The World Health Report 2006: Working Together for Health*, table 1.3, available from www.who.int/whr/2006/whr06_en.pdf?ua=1.

452. Using estimated thresholds of 22.8, 34.5 and 59.4 of skilled health professionals (midwives, nurses and physicians) per 10,000 populations, developed to demonstrate global availability patterns, the WHO report cited above reveals the following findings:[346]

(a) "83 countries fall below the threshold of 22.8 skilled health professionals per 10,000 population"; this represents the lowest numbers of doctors, nurses and midwives needed to provide basic health services;

(b) "100 countries fall below the threshold of 34.5 skilled health professionals per 10,000 population";

(c) "118 countries fall below the threshold of 59.4 skilled health professionals per 10,000 population";

(d) "68 countries are above the threshold of 59.4 skilled health professionals per 10,000 population".

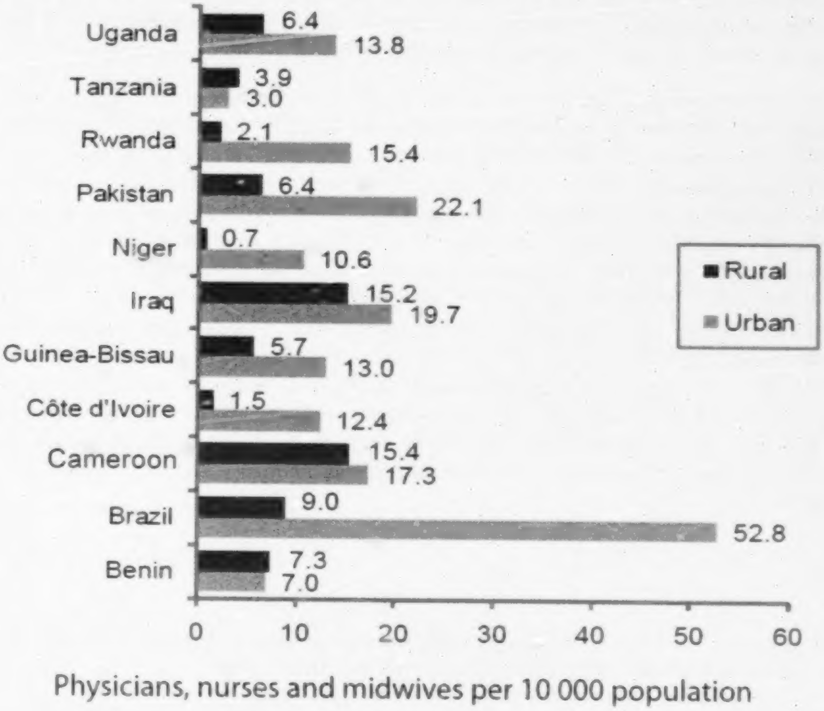
These findings highlight the continued imbalance in the distribution of health workers across countries; further, health worker shortfalls remain most acute in sub-Saharan Africa and parts of Asia.[346]

453. The global distribution of health workers is such that countries with the greatest need and highest disease burdens have the lowest absolute numbers of health workers and health worker densities (i.e., health workers per unit of population). Europe has a health worker density of 18.9 health workers per 1,000 population, which is roughly eight times that of Africa, where the health worker density is 2.3 per 1,000.[347] The Americas bear roughly 10 per cent of the global burden of disease and 37 per cent of the world's health workforce, while Africa bears over 24 per cent of the global burden of disease and has 3 per cent of the global workforce. Among the 49 countries with the lowest per capita income (according to the World Bank), only 5 meet the minimum WHO threshold of 23 doctors, nurses and midwives per 10,000 population.[347]

454. Beyond the shortfall in overall health worker numbers in many countries, shortages are exacerbated by spatial maldistribution within countries, with a greater proportion of health workers, especially the most highly skilled, concentrated in urban centres.[348] Many countries, wealthy and poor, have incentive programmes to address maldistribution, with varying degrees of success. India, for example, is currently experimenting with a rural service programme wherein doctors are rewarded with post-graduate training opportunities following service in a remote or rural area.[349]

Figure 42

Density of physicians, nurses and midwives, urban-rural, selected countries, 2005



Source: WHO, Department of Human Resources for Health, "Monitoring the geographical distribution of the health workforce in rural and underserved areas", Spotlight on Health Workforce Statistics, Issue 8 (October 2009), available from www.who.int/hrh/statistics/spotlight_8_en.pdf.

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[348] L. Chen and others, "Human resources for health: overcoming the crisis", *The Lancet*, vol. 364, No. 9449 (2004), pp. 1984-1990; WHO, "Achieving the health related MDGs: it takes a workforce" (www.who.int/hrh/workforce_mdgs/en/index.html).

[349] "Monitoring the geographical distribution of the health workforce in rural and underserved areas", *Spotlight on Health Workforce Statistics*, No. 8 (October 2009); available from www.who.int/hrh/statistics/spotlight_8_en.pdf; N. Dreesch and others, "An approach to estimating human resource requirements to achieve the Millennium Development Goals", *Health Policy and Planning*, vol. 20, No. 5 (2005), pp. 267-276.

455. The HIV epidemic placed enormous strain on weak health systems, highlighting and exacerbating critical shortages of health workers at the very time that human resources for health were most desperately needed. The HIV epidemic increased the need for health workers to rapidly scale-up treatment, with upper estimates of approximately 120,000 health workers needed to reach the WHO target of providing 3 million people with antiretroviral therapy by 2005.[350] At the same time, poor working conditions created risks for occupational transmission, and increased workload, poor compensation and extremely limited access to essential medicines contributed to low morale and high rates of attrition. Some health workers transitioned to the private sector, which many have argued siphoned critical human resources away from public sector programmes.[351] However, the human resource crisis has generated political will to train and retain health workers and led to the implementation of strategies to relieve pressures on the health workforce, such as task-shifting and scaling up community health worker programmes.[352]

456. The evidence illustrates a strong correlation between low health worker density and poor health outcomes, including the inability to achieve the Millennium Development Goals.[353] While most regions have seen significant advances in the professionalization of birthing care since 2000, the least progress has been made in sub-Saharan Africa (see figure 43), where laypersons and traditional birth attendants attend the majority of births. Less than 55 per cent of women in Africa deliver with a skilled birth attendant, compared with more than 80 per cent of women in the other regions,[354] with Africa falling far short of the targets set for the proportion of births assisted by skilled attendants in the key actions for the further implementation of the Programme of Action (1999).[355] A study of 58 countries in which 91 per cent of all maternal deaths occur found an acute shortage of health workers, and that nine countries needed to increase their midwifery workforce by 6-15 times to meet the Millennium Development Goal target. If the number of trained midwives were doubled in those 58 countries, an estimated 20 per cent of maternal deaths could be averted.[354]

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[350] L. R. Hirschhorn and others, "Estimating health workforce needs for antiretroviral therapy in resource-limited settings", *Human Resources for Health*, vol. 4 (2006).

[351] B. Samb and others, "Rapid expansion of the health workforce in response to the HIV epidemic", *New England Journal of Medicine*, vol. 357, No. 24 (2007), pp. 2510-2514; Yu and others, "Investment in HIV/AIDS program: does it strengthen health systems in developing countries?".

[352] F. Rasschaert and others, "Positive spill-over effects of ART scale up on wider health systems development: evidence from Ethiopia and Malawi", *Journal of the International AIDS Society*, vol. 14, No. 1 (2001), p. S3.

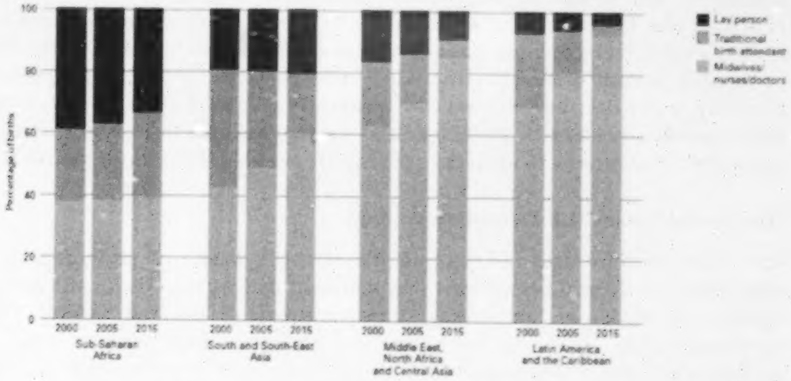
[353] N. Speybroeck and others, "Reassessing the relationship between human resources for health, intervention coverage and health outcomes", background paper prepared for the *World Health Report 2006* (World Health Organization, 2006).

[354] UNFPA, *The State of the World's Midwifery 2011* (see footnote 289 above).

[355] Under the key actions for the further implementation of the Programme of Action, "countries should use the proportion of births assisted by skilled attendants as a benchmark indicator. By 2005, where the maternal mortality rate is very high, at least 40 per cent of all births should be assisted by skilled attendants; by 2010 this figure should be at least 50 per cent and by 2015, at least 60 per cent. All countries should continue their efforts so that globally, by 2005, 80 per cent of all births should be assisted by skilled attendants, by 2010, 85 per cent, and by 2015, 90 per cent" (General Assembly resolution S/21-2, annex, para. 64).

Figure 43

Percentage of births assisted by professionals, selected regions, 2000, 2005 and 2015 (projected)



Source: Adapted from WHO, *The World Health Report 2005: Make Every Mother and Child Count*, in UNFPA, *The State of the World's Midwifery 2011: Delivering Health, Saving Lives*, figure 1.2, available from www.unfpa.org/sowmy/resources/docs/main_report/en_SOWMR_Full.pdf.

457. Many poor countries have responded to the shortage of health workers by "task-shifting", that is, training lower-level staff to assume higher-level functions.[356] Analysts have also increasingly recognized that the adequacy of any national health workforce is a legacy of long-standing dynamics, including the capacity, traditions and adaptability of training institutions, professional incentives and licensing regulations that may be outdated, country-to-country partnerships that may facilitate brain drain, and the institutional culture of health staff.

458. National in-depth and comparative assessments of human resources for health are proving valuable and are reflected in recent work by WHO, the World Bank and UNFPA, each of which have been working on the subject in selected high burden countries. The H4+ High Burden Countries Initiative is embarking on a series of assessments in eight countries to analyse the midwifery workforce, with the ultimate goal of enhancing access to and quality of midwifery services at the community level in a bid to accelerate progress towards the Millennium Development Goals and achieve sustainability of health systems.[357]

459. Health worker assessments, country by country, are sorely needed to provide human resources for health policy diagnostics and the opportunity for scaled planning and redressing health worker shortfalls, and to improve the equitable distribution of care.

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[356] WHO, "Taking stock: task shifting to tackle health worker shortages", document WHO/HSS/2007.03, available from www.who.int/healthsystems/task_shifting_booklet.pdf; K. Sherr and other, "The role of nonphysician clinicians in the rapid expansion of HIV care in Mozambique", *Journal of Acquired Immune Deficiency Syndromes*, vol. 52, No. 1 (November 2009), pp. S20-S23.

[357] H4+ High Burden Countries Initiative (HBCI): operational guidance and assessment framework (April 2012).

460. **States should urgently undertake the necessary long-term investments in training, recruiting and rewarding health-care workers to increase their numbers and strengthen their capacity, with a focus on ensuring that human resources are available to provide universal access to quality sexual and reproductive health services, including by conducting national appraisals and, if necessary, strengthening health training institutions to address the full range of needed sexual and reproductive health services; improving health worker capacity, retention and supervision; investing in mid-level cadres with sexual and reproductive health skills, such as midwives; and improving compensation and career incentives to address geographic maldistribution of health workers.**

3. Health management information systems

461. Another persistent shortfall in the health systems of poor countries is the management information systems that maintain patient records, health statistics and operational data on occupancy rates, outpatient demand, stock flows and reimbursements, enabling managers to evaluate interventions and provider performance, and ultimately ensure an evidence base for planning, managing and improving the health system.[358]

462. As wealthier countries with extensive computer and web access have progressed from paper or e-based management information systems, most poor countries rely on paper-based information systems, interrupting the continuity of care for patients and reducing the efficient use of data. One of the notable changes in health systems since 1994, particularly in the last decade, has been the rapid evolution of Internet capability, making the possibility for a major shift from paper-based to electronic medical record systems, or e-based health management information systems, increasingly feasible.[359]

463. Several recent investments in electronic medical records in poor countries were prompted by HIV and AIDS. The number of untraceable HIV-affected patients highlighted the extreme weakness of health information and medical records systems in many countries. A study of prevention of mother-to-child transmission programmes in 18 countries found that only 9 per cent of infants born to mothers living with HIV were identified at their first immunization visit.[360] As the global community scaled up efforts to deliver antiretroviral therapy in poor countries, HIV and AIDS programmes received targeted investments to track those enrolled in treatment, in order to ensure adherence.[361] Thus, specialized HIV surveillance and adherence monitoring are contributing to the expansion of electronic medical records systems in Africa, but with limited evidence as to whether such

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[358] C. Allen and D. Jazayeri, "Experience in implementing the OpenMRS medical record system to support HIV treatment in Rwanda", in *MEDINFO 2007: Proceedings of the 12th World Congress on Health (Medical) Informatics Studies in Health Technology and Informatics — Building Sustainable Health Systems*, vol. 129, part 1, K. A. Kuhn, J. R. Warren and T-Y. Leong, eds., Studies in Health Technology and Informatics (Amsterdam, IOS Press, 2007), pp. 382-386.

[359] C. AbouZhar and T. Boerma, "Health information systems: the foundations of public health", *Bulletin of the World Health Organization*, vol. 83, No. 8 (2005), pp. 578-583.

[360] A. S. Ginsburg and others, "Provision of care following prevention of mother-to-child HIV transmission services in resource-limited settings", *AIDS*, vol. 21, No. 18 (2007), pp. 2529-2532.

[361] M. Forster and others, "Electronic medical records systems, data quality and loss to follow-up: survey of antiretroviral therapy programmes in resource-limited settings", *Bulletin of the World Health Organization*, vol. 86, No. 12 (2008), pp. 939-947.

developments are being translated across the health sector.[362] **States should reorient the health system to enable continuity of care, through the development of health management information systems that facilitate the mobility of health records and reliable integration of community-based, primary and referral care, with adequate regard for confidentiality and privacy.**

464. Recognizing the potential of electronic medical records for the health sector more broadly, selected countries are working to integrate these systems beyond HIV monitoring, but challenges include lack of qualified technical personnel, sustained Internet coverage and power outages.

465. Paper and non-Internet computer-based health management information systems, while less efficient in many cases, can still have substantial value for health system improvements and accountability. For example, the maternal death surveillance response links health information systems with quality improvement efforts. The implementation of maternal death surveillance response depends heavily on a functioning management information system, but has the potential to reduce maternal mortality irrespective of the form through which such information systems are collected or summarized.[363]

466. Rapid advances in mobile technology since 1994 include global mobile cell coverage of 85.5 per cent in 2011[364] and emerging new opportunities for integration of mobile health information systems have potential for linking and improving care in remote settings. With 70 per cent of all mobile phone users in low- and middle-income countries, the possibilities of reaching the most remote and rural parts of the globe via mobile health information systems holds promise. Multiple initiatives are under way, from weekly maternal death reporting in Cambodia using mobile systems to monitoring stock-outs of reproductive commodities, and using mobile phones to conduct verbal autopsies in countries with high maternal death rates. There remains a substantial need for standardization and established guidelines to enhance interoperability across e-health systems, but the growth in technology offers a genuine possibility for health systems to make major advances in both the operations and utility of their health management information system in the coming decade.[365]

4. Reproductive health commodity security

467. Indeed, the poor operational systems for health management information systems and overall management inefficiencies cause routine bottlenecks that limit chances for quality health service delivery, whether for sexual and reproductive health or other health needs. Commitments to family planning, screening for sexually transmitted infections and maternal health tend to assume the availability of necessary supplies and technologies, yet in conditions of constrained resources,

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[362] Yu and others, "Investments in HIV/AIDS programs: does it help strengthen health systems in developing countries?" (see footnote 342 above).

[363] WHO and others, *Maternal Death Surveillance and Response: Technical Guidance — Information for Action to Prevent Maternal Death* (Geneva, World Health Organization, 2013); available from www.who.int/maternal_child_adolescent/documents/maternal_death_surveillance/en/index.html.

[364] See www.itu.int/ict/statistics.

[365] WHO, *mHealth: New Horizons for Health through Mobile Phone Technologies: Second Global Survey on eHealth*, Global Observatory for eHealth series, vol. 3 (Geneva, World Health Organization, 2011).

inefficient health management information systems and weak programme management, many countries and health systems lack steady funding for supplies and experience poor planning that leads to stock-outs of reproductive health commodities.[366]

468. In the mid-1990s United Nations agencies, government ministries and donors recognized the need to adopt a developmental approach to supply chain and commodity security for family planning and reproductive health, and institutionalized their shared concern for reproductive health commodity security. This is achieved when all individuals can obtain and use affordable, quality reproductive health commodities of their choice, whenever they need them. A series of targeted initiatives were launched, including the Supply Initiative in 2001, the establishment and subsequent expansion in 2004 of the Reproductive Health Supplies Coalition, the UNFPA Reproductive Health and Commodity Security Thematic Fund of 2004 and its Global Programme to Enhance Reproductive Health and Commodity Security of 2007.[367] Additionally, the United Nations Commission on Life-saving Commodities for Women and Children[368] and the Family Planning 2020 initiative[369] will continue to address reproductive health commodity security issues in a coordinated and coherent manner.

469. The principal focus in commodity security efforts has been on the supply side, encompassing forecasting and procurement and extending to infrastructure, including vehicles and trained and motivated personnel. Despite increasing recognition of the need to increasingly stimulate demand for commodities and improve indicators thereof, a clear strategy is yet to be implemented.

5. Universal health coverage

470. An estimated 150 million people suffer financial catastrophe and another 100 million fall under the poverty line each year as a result of out-of-pocket spending on health care. Even worse, high rates of maternal and infant mortality as well as deaths and disabilities from other preventable causes persist because people are unable to access health care.[370]

471. Universal health coverage has garnered increasing international support in recent years. In 2005, the World Health Assembly adopted a resolution encouraging countries to transition to universal health care. The 2010 *World Health Report* focused on financing alternatives to achieve universal health care, and in 2013, the spotlight was on research around universal health coverage. Most developed nations (the notable exception being the United States of America) have universal health coverage; however, among developing nations with significant disease burdens the

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[366] UNFPA, *The Global Programme to Enhance Reproductive Health Commodity Security: Annual Report* (New York, 2010); available from www.unfpa.org/public/home/publications/pid/6437.

[367] J. Solo, "Reproductive health commodity security: leading from behind to forge a global movement" (Reproductive Health Supplies Coalition, 2011); available from www.rhsupplies.org/fileadmin/user_upload/Access/JulieSolo.pdf.

[368] See www.everywomaneverychild.org/resources/un-commission-on-life-saving-commodities.

[369] See www.familyplanning2020.org/images/content/FP2020_ICFP_Release_13-Nov-2013_FINAL.pdf.

[370] K. Xu and others, "Protecting households from catastrophic health spending", *Health Affairs*, vol. 26, No. 4 (2007), pp. 972-983.

challenge of sustainably financing universal health coverage schemes appears daunting.[371]

472. Discussion of what will constitute the package of sexual and reproductive health services that would need to be covered in selected settings is increasingly urgent given the emerging global policy interest in universal health care. It is necessary to identify the core components of essential rights-based sexual and reproductive health services, both in total, and what might be included in stages, through the progressive realization of a universal health-care system, as affirmed by the expert meeting on women's health convened, in the context of the review process beyond 2014, in Mexico City in 2013.

473. There is widespread understanding that health resources go further in a context where both the financing mechanisms and the provision of services prioritize prevention and primary care. And given that much of sexual and reproductive health is best located within prevention and primary care, namely comprehensive sexual education, contraception, antenatal care and skilled delivery, among others, prospects are good for universal health care to include and promote universal access to key elements of sexual and reproductive health. The role of NGO providers may nonetheless be crucial to the provision of comprehensive coverage of sexual and reproductive health, to ensure the provision of key services such as abortion. As such, it will be important to ensure the availability of evidence-based assessments of effectiveness, costs and feasibility of all sexual and reproductive health-related dimensions of care, especially in a diverse range of settings.[372]

474. Success stories of universal health care in poor countries include the roll-out of the Community Based Health Insurance (*mutuelle*) scheme in Rwanda.[373] Utilizing bottom-up and top-down financing arrangements that are tailored to the specific needs of the country has resulted in marked improvements in health insurance coverage, concurrent with a 50 per cent reduction in under-five mortality and a rise in the use of modern contraceptive methods from 10 per cent to 45 per cent.[374] Similar examples suggest enhanced use of sexual and reproductive health services after the removal of user fees in Burundi, Ghana, Nigeria and Mexico.[375]

475. **In establishing universal health-care systems, States should ensure mechanisms for: (a) the fair and affordable participation of all potential beneficiaries in their country; (b) the inclusion of essential sexual and reproductive health services within emerging universal health-care packages and the progressive realization of comprehensive sexual and reproductive health care, especially for young people and the poor; and (c) the assurance of fairness and equality through the participation of civil society, independent**

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[371] WHO, *The World Health Report 2013: Research for Universal Health Coverage* (Geneva, 2013); P. Ingun and others, "The role of information systems in achieving universal health care", Technical Brief Series No. 10 (World Health Organization, 2010).

[372] WHO, *The World Health Report 2013: Research for Universal Health Coverage*.

[373] C. Lu and others, "Towards universal health coverage: an evaluation of Rwanda *Mutuelles* in its first eight years", *Plos One*, vol. 7, No. 6 (18 June 2012).

[374] WHO, "Success stories: building from the bottom, steering and planning from the top — Rwanda" (2011).

[375] D. Varatharajan, S. D'Almeida and J. Kirigia, "Ghana's approach to social health protection", background paper No. 2, prepared for *The World Health Report 2010* (World Health Organization, 2010); available from www.who.int/healthsystems/topics/financing/healthreport/GhanaNo2Final.pdf.

commissions and advocacy groups in the oversight of allowable procedures, providers and reimbursements.

476. Although challenges remain, useful lessons learned from new country roll-outs of universal health care include the need to ensure that the elaboration of service packages are localized, target the poor but monitor the situation of all, pay close attention to the spatial demands of care, and include the anticipation of human resources, infrastructure and commodity needs and of gender inequality and other forms of discrimination. The importance of closely linking sound evidence on population dynamics, including population health data and factors that limit access to health care, to universal health-care planning cannot be overemphasized.[375]

6. Quality assurance

477. Globally, there is greater recognition of the linkages between the quality of health services, utilization rates and health outcomes, as well as the economic returns from upgrading quality.[376] While variations in health-care quality exist within and across regions, the comparatively worse sexual and reproductive health indicators in low- and middle-income countries underscore the need to focus urgently on quality in these regions.

478. Quality assurance systems measure, monitor, control, optimize and modify (where necessary) all components of the health system at all levels of service delivery. Quality assurance is also an essential component of the WHO Health for All strategy. Prior to 1994, Bruce[377] proposed seven elements of quality in family planning programmes, highlighting the urgent need for client-centred counselling and services at a time when many family planning programmes were still structured to meet contraceptive targets. The two decades since the International Conference on Population and Development have generated numerous frameworks, many of which build on Bruce's proposal, through which the quality of sexual and reproductive health services can be conceptualized, measured and monitored.[378] For example, networks of providers and beneficiaries undertake peer-like reviews of other comparable facilities at their level of care, often with excellent results at low cost and measurable improvements in health worker motivation, a significant factor in the quality of care.[379] The Programme of Action placed due emphasis on the formal engagement of civil society in accountability systems, which may extend to quality assurance.

479. A patient's experience while receiving care is an important predictor of the future utilization of such services and has an impact on the care-seeking behaviour of other members of her family and community.[376] Numerous studies undertaken on sexual and reproductive health services report that women place high value on

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[376] WHO, *Quality of Care in the Provision of Sexual and Reproductive Health Services: Evidence from a World Health Organization Research Initiative* (Geneva, 2011).

[377] J. Bruce, "Fundamental elements of quality of care: a simple framework", *Studies in Family Planning*, vol. 21, No. 2 (1990), pp. 61-91.

[378] A. Germain, "Meeting human rights norms for the quality of sexual and reproductive health information and services", background paper prepared for the expert meeting on women's health, rights, empowerment and social determinants, Mexico City, 30 September to 2 October 2013.

[379] L. Creel, J. Sass and N. Yinger, "Overview of quality of care in reproductive health: definitions and measurements of quality", New Perspectives on Quality of Care, No. 1 (Population Council and Population Reference Bureau, 2002).

feeling comfortable and respected over other aspects of care, such as convenience or waiting times.[380] Client characteristics, including differences in socioeconomic status, were associated with levels of client satisfaction; for instance, a study in Argentina reported substantial variation in satisfaction rates among native residents and immigrants in all clinics surveyed.[381]

480. Low-quality care in poorer countries is often attributed to a lack of resources, yet research shows that high-quality care can be achieved in resource-constrained settings. Notably, a study in Indonesia attributed only 37 per cent of perinatal deaths to low resources and over 60 per cent to poor process of service delivery, while another study in Jamaica revealed that improvements in process alone, without added funding, were significantly linked to increased birth weights.[382]

481. Numerous studies emphasize the need for effective and ongoing quality assurance systems, particularly where resource constraints, health-worker shortages and infrastructural limitations exacerbate the strain on health systems. A strategy that maximizes resources with systematic quality assurance can break through to new performance levels in health quality and management.

482. There do not appear to be "magic bullets" to assure equity and quality in service delivery. In order to produce lasting and sustainable improvements, particularly in regions of the world with the worst health outcomes, transformational investments in systems-level approaches are needed. Health systems must be holistically strengthened, and founded on the right to quality care.

483. **States should give the highest priority to strengthening the structure, organization and management of health systems, including the development and maintenance of necessary infrastructure, such as roads, electricity, clean water, facilities, equipment and commodities, to ensure fair and equal access by all persons to comprehensive, integrated and quality primary care that includes sexual and reproductive health care and proximity to referral centres of excellence for higher levels of care, with a commitment to providing universal access to quality health care to all rural, remote and poor populations, indigenous peoples, and all those living without adequate health care today.**

7. Sexual and reproductive health services and rights for refugees and internally displaced persons

484. In 1994, the Women's Commission for Refugee Women and Children[383] published a report documenting the lack of sexual and reproductive health services for refugees and others affected by crises. In the same year the specific reproductive health needs of refugees and internally displaced persons were recognized in the Programme of Action, the Inter-Agency Working Group on Reproductive Health in Crises was formed to strengthen access to quality sexual and reproductive health

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[380] J. M. Turan and others, "The quality of hospital-based antenatal care in Istanbul", *Studies in Family Planning*, vol. 37, No. 1 (2006), pp. 49-60.

[381] M. Cerrutti and B. Freidin, "Analyzing quality of family planning services in Buenos Aires: convergence and discrepancy between users' and experts' views (unpublished report, 2004).

[382] J. Peabody and others, "Improving the quality of care in developing countries", in *Disease Control Priorities in Developing Countries*, 2nd ed., D. T. Jamison and others, eds. (Washington, D.C., World Bank, 2006), chap. 70.

[383] Now the Women's Refugee Commission.

services for persons affected by humanitarian crises such as conflicts and, increasingly, natural disasters.[384]

485. A review undertaken from 2002 to 2004 by the Inter-Agency Working Group found that significant progress had been made in raising awareness and advancing sexual and reproductive health for populations affected by conflict, particularly in stable refugee camp settings. Nonetheless, critical gaps were noted, especially for gender-based violence and HIV and AIDS, and sexual and reproductive health services for internally displaced persons were severely lacking.

486. Standardized tools now provide normative guidelines for sexual and reproductive health programming in crises, including the Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings[385] and the Minimum Initial Service Package for Reproductive Health, which was integrated into the 2004 and 2011 Sphere standards that provide universal minimum standards for humanitarian response. The Minimum Initial Service Package is now part of the numerous high-level policy documents and guidelines for crisis settings,[386] and a 2013 assessment of the Package in Zaatri refugee camp and Irbid city in Jordan suggests that priority reproductive health services are integrated into the response to the crisis in the Syrian Arab Republic.[387]

487. Need has not abated. An estimated 44 million people worldwide are currently displaced by conflict, and an additional 32 million are displaced by natural disasters. Today, more than half of the refugees served by the Office of the United Nations High Commissioner for Refugees (UNHCR) live in urban areas, as opposed to camp settings, and internally displaced persons often live in host communities or are dispersed over large geographical areas. Such changes in the spatial distribution of internally displaced persons raise new service challenges, prompting a recent review to advise on future programming.

488. Lack of integration or mainstreaming of sexual and reproductive health into acute emergency responses remains a challenge. In complex emergencies, sexual and reproductive health often takes a back seat, and the quality and range of sexual and reproductive health services suffers. While the latest review by the Inter-Agency Working Group finds services more available today than 10 or 20 years ago, the services are often not comprehensive, and selected components of the Minimum Initial Service Package are implemented rather than the comprehensive package. There are gaps in the availability of contraceptive methods, with no long-term or permanent methods or no contraceptive services available for adolescents or unmarried people, while services addressing gender-based violence, safe abortion

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[384] Originally named "Inter-Agency Working Group on Reproductive Health in Refugee Situations". Today the Working Group has grown to include over 450 broad-based member agencies, including roughly 1,500 individuals from United Nations agencies, Governments, non-governmental organizations, universities and donor organizations.

[385] Office of the United Nations High Commissioner for Refugees (UNHCR) and Women's Refugee Commission, "Refocusing family planning in refugee settings: findings and recommendations from a multi-country baseline study" (November 2011).

[386] Including the Inter-Agency Standing Committee *Guidelines for Gender-based Violence Interventions in Humanitarian Settings* and *Gender Handbook in Humanitarian Action; Health Cluster Guide: A Practical Guide for Country-level Implementation of the Health Cluster* (World Health Organization, 2009).

[387] UNHCR, Inter-Agency Working Group on Reproductive Health in Crises, *Reproductive Health Services for Syrian refugees in Zaatri Refugee Camp and Irbid City, Jordan: An Evaluation of the Minimum Initial Service Package — 17-22 March 2013* (2013).

care, post-abortion care, sexually transmitted infections and adolescent sexual and reproductive health are still limited.

489. **Global efforts are necessary to ensure that sexual and reproductive health services for refugees and internally displaced persons comprehensively respond to identified gaps, including services to address gender-based violence, greater access for unmarried and young people, and the provision of multiple types of contraception.**

490. A stronger evidence base is needed. In addition, increased and enhanced monitoring is needed to document the outcomes and impact of existing programmes. Preliminary results from a recent study by Research for Health in Humanitarian Crises, funded by the United Kingdom (Department for International Development) and the Wellcome Trust, found that existing evidence on health needs and services in crisis settings is generally weak, including for sexual and reproductive health.

8. Government priorities: sexual and reproductive health and rights

Global sexual and reproductive health priorities	
Sexual and reproductive health services for adolescents and youth	56 per cent of Governments
Maternal and child health	51 per cent of Governments
HIV- and sexually transmitted infection-related services	43 per cent of Governments
Family planning services	38 per cent of Governments
Reproductive cancers	36 per cent of Governments

Africa region — Sexual and reproductive health priorities	
Maternal and child health	71 per cent of Governments
HIV- and sexually transmitted infection-related services	56 per cent of Governments
Sexual and reproductive health services for adolescents and youth	56 per cent of Governments
Family planning services	46 per cent of Governments
Reproductive cancers	42 per cent of Governments
Americas region — Sexual and reproductive health priorities	
Sexual and reproductive health services for adolescents and youth	74 per cent of Governments
Maternal and child health	42 per cent of Governments
HIV- and sexually transmitted infection-related services	42 per cent of Governments

Maximize social inclusion, equal access and rights to sexual and reproductive health	42 per cent of Governments
Family planning services	32 per cent of Governments
Asia region — Sexual and reproductive health priorities	
Sexual and reproductive health services for adolescents and youth	56 per cent of Governments
Maternal and child health	54 per cent of Governments
Family planning services	46 per cent of Governments
Reproductive cancers	37 per cent of Governments
Maximize social inclusion, equal access and rights to sexual and reproductive health	27 per cent of Governments
HIV- and sexually transmitted infection-related services	27 per cent of Governments
Europe region — Sexual and reproductive health priorities	
HIV- and sexually transmitted infection-related services	55 per cent of Governments
Maximize social inclusion, equal access and rights to sexual and reproductive health	48 per cent of Governments
Sexual and reproductive health services for adolescents and youth	45 per cent of Governments
Maternal and child health	39 per cent of Governments
Reproductive cancers	35 per cent of Governments
Oceania region — Sexual and reproductive health priorities	
Family planning services	58 per cent of Governments
Sexual and reproductive health services for adolescents and youth	42 per cent of Governments
Violence	33 per cent of Governments
Maximize social inclusion, equal access and rights to sexual and reproductive health	33 per cent of Governments
Develop sexual and reproductive health policies, programmes and laws	33 per cent of Governments

491. Notably, the most frequently mentioned sexual and reproductive health priority (by 57 per cent of Governments worldwide) was "sexual and reproductive health services for adolescents and youth". Given that today's youth cohort far exceeds those of previous generations, it is critical that their needs, particularly their sexual and reproductive health needs, be addressed. The second most frequently mentioned priority, "maternal and child health", was largely driven by the numbers of African

and Asian countries where maternal mortality remained markedly prevalent and constituted significant health concerns. Interestingly, reproductive cancers, which includes breast and cervical malignancies, in fifth place globally, was highlighted by comparatively more high-income non-OECD countries (50 per cent) and low-income countries (41 per cent) than countries in other income groupings.

492. When countries were grouped by income, "sexual and reproductive health for adolescents and youth", "maternal and child health" and "family planning" were more frequently mentioned as priorities by Governments of low- and lower-middle-income countries, whereas "social inclusion, equality of access and rights" and "HIV- and sexually transmitted infections-related services" stood out as a priority among high-income OECD countries, mentioned by 58 per cent of their Governments.

493. The patterns described above reiterate the inextricable linkages between health and wealth. Developing countries still lack essential building blocks of strong health systems, which are necessary for the provision of basic maternal and child health services. This is evident in the persistently high maternal and infant mortality and morbidity rates seen in these countries. The survey results highlight the recognition by Governments of the necessity of prioritizing those dimensions of sexual and reproductive health services for which there is the greatest need.

Priorities of civil society organizations regarding sexual and reproductive health and reproductive rights

A recent (2013) survey among 198 civil society organizations in three regions that work in sexual and reproductive health and reproductive rights showed that in Africa, 26 per cent of civil society organizations identified the "development of programmes, policies, strategies, laws and the creation of institutions" as the one top priority issue for public policy for the next 5-10 years. In contrast, "abortion" was the most frequently cited issue by civil society organizations in the Americas (29 per cent) and Europe (25 per cent). In the latter region, 20 per cent of civil society organizations identified "targeted sexual and reproductive health for adolescents and youth", that is, information, counselling and services, as the one top priority issue for public policy in the near future.

H. Health: key areas for future action

1. Accelerate progress towards universal access to quality sexual and reproductive health services and fulfilment of sexual and reproductive rights.

494. An alarmingly high proportion of people continue to live without access to sexual and reproductive health services, particularly the poor. Economic growth, by itself, is insufficient to ensure universal, equitable coverage, and therefore countries must dedicate resources to ensure that all persons have access to affordable, quality care. Current discussions give considerable weight to "universal health coverage" as a means to assure that all persons have access to health care without financial hardship.

495. The highest priority should be to strengthen primary health-care systems to make integrated, comprehensive, quality sexual and reproductive health services, with adequate referrals, accessible to where people, especially rural, remote and resource-limited populations, including the urban poor, live. These efforts should ensure the availability of the widest range of technologies and commodities, as well as the strengthening of health management information systems.

496. Special attention should be directed towards ensuring that human resources are available and accessible to provide comprehensive, quality sexual and reproductive health services, including by investing in the capacity of health workers, particularly mid-level cadres such as midwives, addressing maldistribution and strengthening health training institutions.

497. Improved availability and accessibility must be coupled with improved quality of sexual and reproductive health services to support each person in a holistic and integrated way, protect the human rights of all persons, and ensure the privacy and confidentiality of services and information regarding patient rights.

2. Protect and fulfil the rights of adolescents and youth to accurate information, comprehensive sexuality education and health services for their sexual and reproductive well-being and lifelong health.

498. Rates of sexually transmitted infection and HIV infection and AIDS-related mortality, abortion-related deaths and maternal deaths among young people reveal the urgent need to address the inadequate access to information and services currently experienced by the largest generation of adolescents and youth in history.

499. Greater investment must be made in information and services so they are accessible and acceptable to adolescents and youth. Programme monitoring and evaluation should explicitly assess the extent to which adolescents are being reached, and which interventions bring the greatest long-term health and well-being for young people.

500. The sexual and reproductive health of adolescent girls requires ending gender inequality in education, adopting and enforcing a legal minimum age of marriage of 18 years, eradicating female genital mutilation/cutting and other harmful practices, and eliminating all forms of discrimination and violence against girls. Such protections of adolescents and youth are essential in order to create a society in which they can build their capabilities, expand their education and enter freely into marriage and childbearing.

501. To realize sexual and reproductive health and rights, adolescents and youth, both in and out of school, should receive comprehensive sexuality education that emphasizes gender equality and human rights, including attention to gender norms, power and the social values of equality, non-discrimination and non-violent conflict resolution. Such programmes can also empower young people to adopt healthy behaviours, with lifelong benefits for themselves and for society at large.

502. All programmes serving adolescents and youth, in and out of school, must provide referral to reliable, quality sexual and reproductive health counselling and services, as well as other health services including mental health. Legal, regulatory and policy barriers limiting young people's access to sexual and reproductive health services should be removed.

3. Strengthen specific sexual and reproductive health services.

Contraception

503. The availability and accessibility of the widest possible range of contraceptive methods, including emergency contraception, with adequate counselling and technical information, to meet individuals' and couples' contraceptive needs and preferences across the life course, are essential for reproductive health and reproductive rights. Yet some countries provide only a few methods, or do not make options or information widely available that would enable individuals to exercise free and informed choice, especially where health systems are weak, for example in rural areas. Decisions about what contraceptive mix to provide must be calibrated to the capacity of health service providers, while also building the health system and the capacity of health workers to provide a range of methods to meet the needs and preferences for everyone across the life course.

Abortion

504. With increasing access to safe abortion and post-abortion care, abortion rates as well as rates of abortion-related deaths have decreased globally, with significant regional variation. However, progress is inadequate as death rates resulting from unsafe abortion remain unacceptably high in Africa and South Asia, with more than half of these deaths occurring among young women under 25 years. Concrete measures are urgently needed to:

(a) Reduce unplanned pregnancies by increasing access to contraception and fulfilling the rights of women and girls to remain free from forced or coerced sex and other forms of gender-based violence;

(b) Ensure access to quality post-abortion care for all persons suffering from complications of unsafe abortion;

(c) Take action as indicated in the WHO publication *Safe Abortion: Technical and Policy Guidance for Health Systems*, to remove legal barriers to services;

(d) Ensure that all women have ready access to safe, good-quality abortion services.

Maternity care

505. Ninety per cent of maternal deaths are preventable, and the elimination of all preventable deaths requires a well-functioning and integrated primary health-care system that is close to where women live; effective referral mechanisms to respond to complications of pregnancy and delivery; and the availability and accessibility of functioning basic and comprehensive emergency obstetric care. To achieve universal availability and accessibility of quality maternity care requires strengthening the health system, particularly in sub-Saharan Africa and South Asia.

506. For each woman who dies of a pregnancy-related complication, an estimated 20 women suffer serious and often lifelong morbidities such as obstetric fistula, uterine prolapse, incontinence or severe anaemia. Maternal morbidity and case fatality rates should be increasingly utilized as indicators of the quality of sexual and reproductive health services and the progressive realization of women's right to health.

Sexually transmitted infections, including HIV

507. Evidence suggests a 40 per cent increase in the annual incident cases of sexually transmitted infections since the International Conference on Population and Development, yet data reflect widespread weakness in surveillance. Despite the facts that sexually transmitted infections have serious consequences for women's health and fertility, contribute to miscarriage and low birth weight and can cause congenital disorders, these infections remain among the most poorly monitored, diagnosed or treated sexual and reproductive health conditions worldwide. Enhanced global commitment towards strengthening sexually transmitted infection surveillance and increasing access to effective prevention, diagnosis and treatment of sexually transmitted infections for all persons, particularly young people, is sorely needed.

508. Continued investment is also required to achieve universal access to HIV prevention, treatment and care, and to accelerate full integration of HIV and other sexual and reproductive health services in a manner that will holistically strengthen health systems. Further, it is necessary to scrutinize and address the structural conditions that may be contributing to the persistence of new HIV infections in Southern Africa.

Non-communicable diseases, including reproductive cancers

509. The prevalence, and attendant mortality and morbidity resulting from reproductive cancers further highlight the inadequacy and inequalities in access to sexual and reproductive health information, education and services globally.

510. More than half a million women each year develop cervical cancer, which is responsible for the death of over half that number of women, predominantly in developing countries, and which is preventable through screening and the human papilloma virus vaccine. Despite lower incidence of breast cancer in developing countries, mortality rates are higher owing to a lack of access to screening and treatment.

511. In all regions of the world except Africa, where there is a double burden, deaths from non-communicable diseases exceed those caused by maternal, perinatal, communicable and nutritional disorders combined, and related mortality is occurring at earlier ages in developing countries. Cardiovascular diseases, cancers, diabetes, depression and chronic respiratory diseases are responsible for the majority of non-communicable illnesses and deaths. This changing burden of disease reflects significant changes in tobacco use, harmful use of alcohol, insufficient physical activity and unhealthy diet/obesity.

512. It is critical to address the rising burden of reproductive cancers, including breast, cervical and prostate cancers, by investing in prevention strategies including the human papilloma virus vaccine and routine screening, early treatment at the primary care level and reliable referrals to higher levels of care.

513. It is also necessary to reduce risk factors for non-communicable diseases through the promotion of healthy behaviours and lifestyle choices, particularly among children, adolescents and youth.

IV. Place and mobility

"[Human beings] have the right to an adequate standard of living for themselves and their families, including adequate food, clothing, housing, water and sanitation."

(Programme of Action, principle 2)

"Countries should guarantee to all migrants all basic human rights as included in the Universal Declaration of Human Rights."

(Programme of Action, principle 12)

"Governments should improve the management and delivery of services for the growing urban agglomerations and put in place enabling legislative and administrative instruments and adequate financial resources to meet the needs of all citizens, especially the urban poor, internal migrants, older persons and the disabled."

(Key actions for the further implementation of the Programme of Action, para. 31)

514. The importance of place to human security coincides with impressive evidence of our very human relationship with migration. We are neither migratory nor sedentary; we do not routinely or instinctively change our habitation with the seasons, but carry within us the uniquely human capacity for both deep attachment to place and the impulse to seek new and better places to make our homes. Our public policies, therefore, need to accommodate human needs for both a secure place and mobility.

515. Place is both social and spatial.[388] It includes our family, household and community, which provide the moveable social fabric linking us to one other. And place includes the village, municipality, state and country we call our own, embedding us within a shared environmental niche and political structure.

516. A secure place is essential for human development, as human security — that is, freedom from hunger, fear, violence and discrimination — is a precondition for the development of children and the creative growth of all persons. The foundational human rights instruments protect rights related to human security through the "right of everyone to an adequate standard of living … including adequate food, clothing and housing, and to the continuous improvement of living conditions", as well as to mobility, including a person's "right to liberty of movement and freedom to choose his residence" and the freedom to "leave any country".[389]

517. Increasing numbers of people around the world are moving, both within national borders and internationally. A secure place for people on the move is essential, underscoring the importance of planning for rapidly growing cities that can integrate and support rural-urban migrants as well as the urban poor.

518. Yet the scale of the human population living day to day without a safe or reliable home underscores the urgency of enhanced global attention to human security. At the end of 2012, there were at least 15.4 million refugees,[390]

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[388] T. F. Gieryn, "A space for place in sociology", *Annual Review of Sociology*, vol. 26 (2000), pp. 463-496.

[389] See article 11 of the International Covenant on Economic, Social and Cultural Rights and article 12 of the International Covenant on Civil and Political Rights (General Assembly resolution 2200 A (XXI), annex).

[390] UNHCR, "Displacement, the new 21st century challenge", *Global Trends 2012* (Geneva, 2013).

28.8 million internally displaced persons[391] and an estimated 863 million persons living in slums,[392] with a large but ultimately unknown population completely homeless. These challenges demand cooperative partnerships between Governments for inclusive land-use planning, linked urban and rural health systems, and commitments to fulfil the need for safe and secure housing.

519. This section reviews emerging changes in the structure of households, people's most immediate place. It gives prominence to internal and international mobility as they define people's prospects, as well as to urbanization as the dominant spatial transition currently under way in much of the world. It highlights some of the most vital threats to place, such as homelessness, displacement, and lack of access to land.

Human rights elaborations since the International Conference on Population and Development

Box 19

Freedom of movement

Other soft law. General comment No. 27 on freedom of movement (1999) adopted by the Human Rights Committee states, "Liberty of movement is an indispensable condition for the free development of a person." The general comment clarifies rights related to liberty of movement; the freedom to choose one's place of residence; the freedom to leave any country, including one's own; the right to enter one's own country; and the exceptional circumstances under which the State can restrict these rights, noting that the "application of the restrictions permissible under article 12, paragraph 3 [of the International Covenant on Civil and Political Rights], needs to be consistent with the other rights guaranteed in the Covenant and with the fundamental principles of equality and non-discrimination".

A. The changing structure of households

520. The Programme of Action of the International Conference on Population and Development called on States to develop policies to provide better social and economic support to families, acknowledge the rising cost of child-rearing, and provide assistance to the rising number of single-parent households. The Programme of Action recognized that the family could take various forms. However, little mention was made of prevailing trends in family or household structures at the time, other than the noted rise in single-parent households. It did not anticipate the growing instability of marital unions in many societies, or the growing heterogeneity of household structures and living arrangements, including the one-person, single-parent, child-headed and grandparent-headed households that characterize many families today.

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[391] Internal Displacement Monitoring Centre and Norwegian Refugee Council. *Global Overview 2012: People Internally Displaced by Conflict and Violence* (Geneva, 2013).

[392] United Nations Human Settlements Programme (UN-Habitat), *State of the World's Cities 2012/2013: Prosperity of Cities* (Nairobi, 2012).

521. Hence, the principal objectives of the Programme of Action — to ensure that families and households have secure homes and that parents have the opportunity to give due attention to the well-being of their households, especially their children — needs to be reaffirmed in 2014, given that households are growing increasingly more diverse in structure, that a rising number of persons live alone, and that children worldwide are more likely to be raised by a single parent.[393]

1. The rise in one-person households

522. In the two decades since the International Conference on Population and Development, several converging social trends, such as the rise in age at marriage, rates of divorce and proportions of persons who never marry, along with medical innovations, have led to increases in the number of one-person households, especially in European and other developed countries,[394] in a wide range of Latin American and Caribbean countries, and in selected countries in Asia, notably the Republic of Korea, the Philippines, Singapore, Indonesia, Thailand and Viet Nam (see figure 44). There is very little evidence of a measurable rise in single-person households in African countries, outside of Kenya. The rise in single-person households has far-reaching implications for patterns of consumption, housing, long-term care of the elderly and intergenerational support and, therefore, demands on the State.

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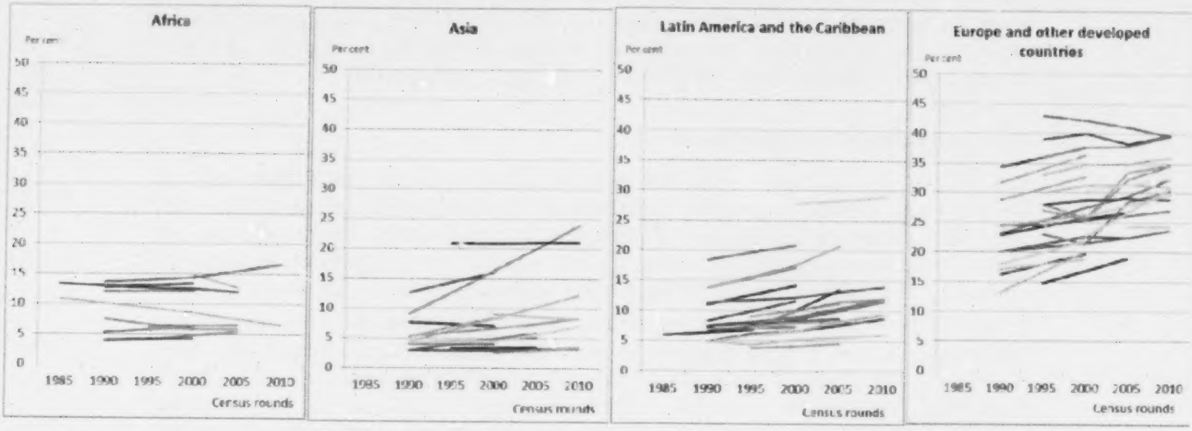
[393] OECD, *The Future of Families to 2030: A Synthesis Report* (Paris, OECD Publishing, 2011); National Health and Family Planning Commission of China, "The People's Republic of China country report on population and development" (September 2013); J. C. Olmstead, "Norms, economic conditions and household formation: a case study of the Arab world", *The History of the Family*, vol. 16, No. 4 (2011), pp. 401-415; A. Esteve and others, "The 'Second Demographic Transition' features in Latin America: the 2010 update" (2012).

[394] OECD, *The Future of Families to 2030: A Synthesis Report.*

Figure 44

Trends in the proportion of one-person households, by region



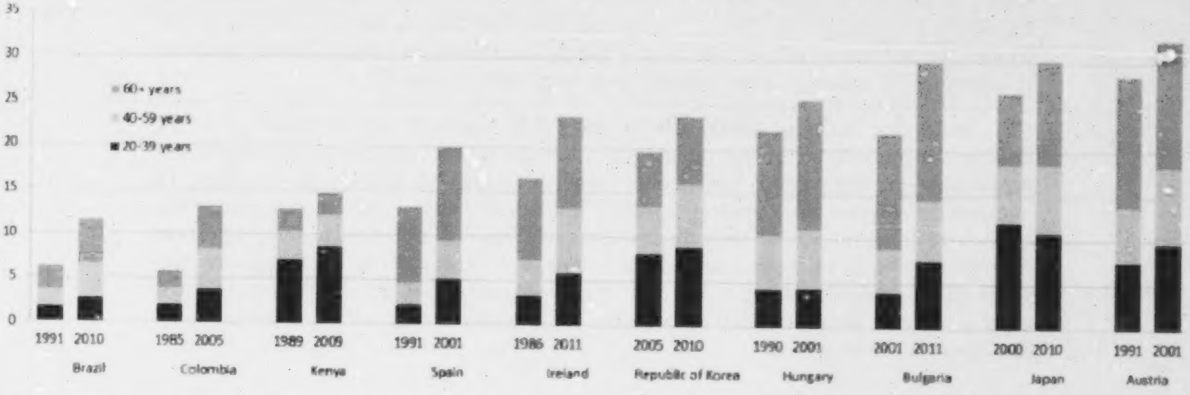
Source: United Nations, *Demographic Yearbook*, table 2, Households by type of household, age and sex of head of household or other reference member, 1995-2013, available from http://unstats.un.org/unsd/demographic/products/dyb/dyb_Household/dyb_household.htm (accessed on 26 September 2013); United Nations Statistics Division, special data request/interagency communication, June 2013; Minnesota Population Center, Integrated Public Use Microdata Series, International: Version 6.2 [Machine-readable database], University of Minnesota, 2013 (data retrieved on 23 September 2013); Socio-Economic Database for Latin America and the Caribbean (Centro de Estudios Distributivos, Laborales y Sociales (Argentina) and World Bank), 2013, table, Household structure, in "Statistics by gender", available from http://sedlac.econo.unlp.edu.ar/eng/statistics-by-gender.php; Eurostat, 2013, Statistics on Income and Living Conditions Database, table, Income and living conditions/private households/distribution of households by household type, 1997-2001 and 2003-2011, available from http://epp.eurostat.ec.europa.eu/portal/page/portal/statistics/themes.

Note: Data from censuses are organized in time periods centred on census rounds (plus/minus two years around 1985, 1990, 1995, 2000, 2005, 2010); data from surveys are averaged within each of the time periods.

523. The rise in one-person households reflects social changes under way across the life course, among both young adults and older persons, which shape the rise in single-person households to greater or lesser degrees in different regions. Figure 45 shows that Spain, Hungary and Bulgaria have a relatively higher proportion of older persons (over 60 years) in one-person households (as a proportion of total households), which may reflect long-term health and independence, but may also foreshadow a future need for assisted living. Austria, Japan, Kenya and the Republic of Korea, by contrast, have a relatively higher proportion of one-person households among 20- to 39-year-olds, suggesting delayed marriage, or bachelorhood, with heightened demand for single-unit housing, entertainment and certain consumer goods.

Figure 45

Trends in the proportion of one-person households, by age category



Source: United Nations, *Demographic Yearbook*, table 2, Households by type of household, age and sex of head of household or other reference member, 1995-2013, available from http://unstats.un.org/unsd/demographic/products/dyb/dyb_Household/dyb_household.htm (accessed on 26 September 2013); United Nations Statistics Division, special data request/interagency communication, June 2013; Minnesota Population Center, Integrated Public Use Microdata Series, International: Version 6.2 [Machine-readable database], University of Minnesota, 2013 (data retrieved on 23 September 2013).

524. Females are more likely than males to live in one-person households in Europe and other developed countries, but the reverse is true in countries in Africa and in Latin America and the Caribbean. Women form the majority of persons living in one-person households among older persons and among the widowed. On the other hand, in most countries men constitute the majority of persons who were never married living alone. Women remain underrepresented among young persons living alone, especially in the less developed regions. Only a small increase in their proportion was noted for countries in both developed and less developed regions.

525. A selection of 21 countries have data on one-person households by place of residence (urban/rural) and age of the household member. Among the seven African countries, one-person households are more common in urban areas, especially those composed of young adults (20-39 years). In the Latin American, Asian and the three European countries, the pattern is mixed regarding whether one-person households are predominant in rural or urban areas but, as in Africa, one-person households composed of young adults are more common in urban areas. Only in Argentina are young people living alone equally likely to live in either urban or rural areas. Conversely, older one-person households are more common in rural than in urban areas in the majority of countries.

2. Delayed marriage

526. Among young adults, the rise in one-person households reflects, in part, the continuing global rise in the age of first marriage (see figure 46). The singulate mean age at marriage for women and men has increased in both more developed and less developed regions for the past 50 years, but more in the former.[395] When combined with an especially large cohort of young adults (15-24 years old) in Asia

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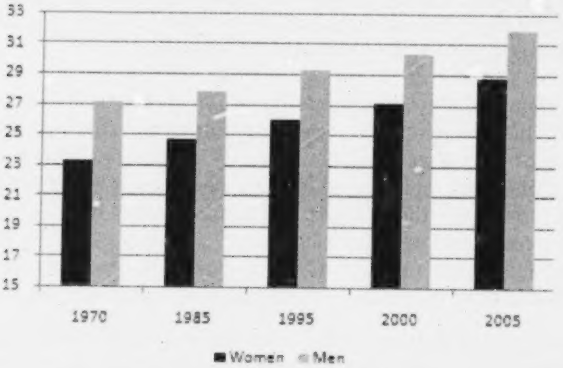
[395] *World Fertility Report 2009* (ST/ESA/SER.A/304).

and the Americas (18.3 and 18.0 per cent of total population, respectively),[396] this contributes to an overall rise in single-person households in young adulthood. And while young adult cohorts are a smaller proportion of the overall population in Europe (12.8 per cent in 2010),[396] there too there has been a measurable rise in the likelihood that young adults will form independent and shared-peer households prior to marriage,[397] although many remain in their parents' home.[398]

527. Younger cohorts of adults (20-39 years old) represent the dominant group of one-person households in less developed countries. In fact, the small increase in the proportion of one-person households seen in Kenya is due to an increase in one-person households among young adults. But the rise in single-person households also reflects at least three other social trends: a decline in the proportion of persons who have "ever married", a rise in divorce occurring in all regions, and gains in life expectancy that increase the probability that all older persons, and elderly women in particular, will spend more years living alone, whether after divorce or widowhood.

Figure 46

Singulate mean age at marriage by sex, 1970-2005



Source: United Nations, World Marriage Data 2012 (POP/DB/Marr/Rev2012), available from www.un.org/en/development/desa/population/publications/dataset/marriage/wmd2012/MainFrame.html.

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[396] *World Population Prospects: The 2012 Revision* (see footnote 336 above).

[397] S. Heath, "Young, free and single? The rise of independent living", in *Handbook of Youth and Young Adulthood: New Perspectives and Agendas*, A. Furlong, ed. (Milton Park, Abingdon, Oxon, Routledge, 2009).

[398] M. Iacovou, "Leaving home: independence, togetherness and income in Europe". Expert Paper No. 2011/10, prepared for the Expert Group Meeting on Adolescents, Youth and Development, New York, 21 and 22 July 2011; Eurostat database, data downloaded 11 December 2013.

3. Rise in the proportion of the population who never marry

528. Historically, a rise in the proportion of persons who never marry has been observed among cohorts coming of age in wartime, owing to the shortage of prospective marriage partners.[399] Looking exclusively at the proportion of women aged 45-49 who have never married, census-based trends of the past 40 years suggest a persistent rise across a majority of countries in Europe, Africa, Oceania and the Americas,[400] most of which were not experiencing war or sustained conflict. Only in Asia is there a uniformly sustained low rate of never-married middle-aged women. Statistics on non-marriage may reflect a competing rise in less formal unions such as cohabitation, which look very much like marriage (including lifetime security and raising a family), thereby suggesting greater changes to the social fabric than is actually occurring. The trends are notable nonetheless, contributing, in part, to the more significant rise in one-person households.

529. In Africa, an analysis of nine countries, with trend data drawn from censuses, shows that the percentage of never-married women aged 45-49 remains low (less than 10 per cent), but has increased significantly in the last two decades in six countries — Lesotho, Liberia, Libya, Mozambique, the Niger and the Sudan — but not in three countries — Burkina Faso, Egypt and Ethiopia.[401]

530. In the Americas, the percentage of never-married women aged 45-49 exceeds 10 per cent in all 12 countries where trend data are available, although it has remained constant in most countries for the past two or three decades.

531. In Asia the percentage of never-married women aged 45-49 tends to be lower (about 5 per cent), with a few exceptions in countries such as Kuwait, Qatar and Singapore, where it exceeds 10 per cent and has seen steep increases over the past 20 years.

532. Within the 25 European countries with trend data available, close to or over 20 per cent of women aged 45-49 have never married in Denmark, Finland, France, Germany, Ireland, the Netherlands, Norway and Sweden; this proportion has increased steadily since the 1980s or 1990s. The proportion of never-married women has been increasing for 20 years in Austria, Belgium, Iceland, Latvia and Switzerland, and is now between 10 and 20 per cent. The proportion ranges from 5 to 10 per cent in Albania, Belarus, Hungary and the Russian Federation, and has remained relatively constant over the past three decades.

533. Finally, in Oceania (Australia, New Zealand, Palau and Tonga), the proportion of never-married women aged 45-49 has increased rapidly over the past 30 years, and is now approximately 10 per cent.

4. Rise in divorce

534. The proportion of persons divorced or separated has also increased in the last two decades,[401] and is evident in all regions to varying degrees. The proportion of

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[399] R. Abramitzky, A. Delavande and L. Vasconcelos, "Marrying up: the role of sex ratio in assortative matching", *American Economic Journal: Applied Economics*, vol. 3, No. 3 (2011), pp. 124-157; E. Brainerd, "Uncounted costs of World War II: the effect of changing sex ratios on marriage and fertility of Russian women" (October 2007), available from http://web.williams.edu/Economics/faculty/brainerd-rfwomen.pdf.

[400] UNFPA, secondary analysis of *World Marriage Data 2012* (www.un.org/esa/population/publications/WMD2012/MainFrame.html).

[401] *World Marriage Data 2012*.

women and men aged 45-49 who are currently divorced or separated is highest in European and other high-income countries, and has increased the most in the past 20 years. The proportion of countries in which at least 10 per cent of the population aged 45-49 (male and female) are divorced or separated is 67 per cent in Europe (29 of 43 countries); 45 per cent in the Americas (19 of 42 countries); 41 per cent in Africa (19 of 46 countries); and only 11 per cent in Asia (5 of 43 countries). Even in many countries where proportions are low (affecting less than 5 per cent of middle-age persons), recent trends are upwards, and steep. For example, while only 2.1 per cent of those 45-49 years old are divorced or separated in China, this represents a five-fold increase over the past 20 years. Similar increases in Eastern Europe and South Asia suggest a fairly recent loosening of historic restrictions (legal or social) on divorce, with rapid increases from zero or near zero in the last 10 to 20 years.

535. In summary, the observed rise in one-person households globally reflects numerous social changes, including delayed marriage, non-marriage, divorce and widowhood. Overall, more countries have had an increase in the proportion of one-person households due to a rising proportion of never-married persons, young and old (23 of 52 countries with available data, from developed and less developed regions). Far fewer countries have observed a rise in one-person households due to divorce or separation (14 countries, mostly from developed regions). Still fewer countries (seven countries, five of which are in Latin America and Asia) have seen a rise in their proportion of one-person households due to widowhood. There is a very small proportion of one-person households composed of married individuals or individuals in union (suggesting sustained separation, possibly due to migrant labour), which has nevertheless increased in Senegal, Colombia, Chile, the Plurinational State of Bolivia, the Republic of Korea, Bulgaria and Switzerland.

5. Single-parent households

536. Single parents with children represent a significant proportion of all households in countries in all regions. The highest prevalence is observed in Latin America and the Caribbean. Among the countries with available data, over 10 per cent of households are composed of single parents with children in 7 of 12 countries in Latin America and the Caribbean, 5 of 17 countries in Europe and 3 of 11 countries in Africa. However, these proportions are likely to be underestimates, as they do not include families of single parents with children who may co-reside with other family or non-family members in non-nuclear households (i.e., extended or composite households).

537. Trends in the proportion of single-parent households have been mixed. In Latin America and the Caribbean, almost all countries experienced an increase, the largest being observed in Colombia, Ecuador and El Salvador. Increases were also observed in some European countries (the Russian Federation and Ireland) and in some African countries (Cameroon, Rwanda and the United Republic of Tanzania). Decreases in the proportion of single-parent households were observed in some countries in different regions, the highest being in Cambodia, the Czech Republic, Malawi, South Africa and Viet Nam.

538. The most recent data available show that the majority of single parents living with their children are women, ranging from slightly less than three quarters in the Philippines (2000), Bermuda (2010), the Republic of Korea (2010), Turkey (2000) and Japan (2010) to more than 90 per cent in Rwanda (2002) and Malawi (2008).[402]

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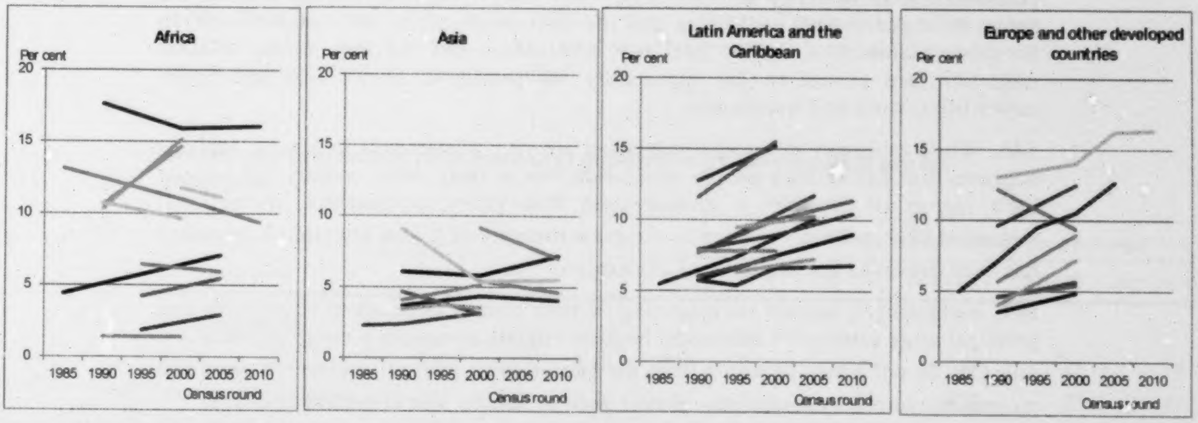
[402] UNFPA, analysis of data from Integrated Public Use of Microdata Series and United Nations, Department of Economic and Social Affairs, Statistics Division.

539. The proportion of single-parent households is higher in urban than in rural areas for about half of countries with available data, most of them located in Latin America and the Caribbean and in Europe, while it is higher in rural areas for about one fifth of countries, most of them located in sub-Saharan Africa.[402] The increases observed for some countries in the proportion of single-parent households are due to changes in both urban and rural areas, but mainly in urban areas.

540. Children living in single-parent households may more often experience economic poverty and limited access to basic services of education and health. In the last two decades, the proportion of 0- to 14-year-old children living in single-parent households has increased in most countries of Europe and other more developed regions, and Latin America and the Caribbean (see figure 47). Among the countries with the highest current values (over 10 per cent) are Austria, Ireland, the United States of America, the Plurinational State of Bolivia, Colombia, Ecuador, El Salvador, Jamaica, Panama and Peru. In Africa, trends have been mixed. For example, in Rwanda and the United Republic of Tanzania, the proportion of children living in single-parent households has increased, reaching about 15 per cent. On the other hand, the proportion has decreased but remained high in Kenya and Malawi, at 16 per cent and 9 per cent, respectively. In Asian countries, the proportion of children in single-parent households has changed the least, and remained the lowest.

Figure 47

Trends in the proportion of children (0-14 years old) living in single-parent households, by region



Source: Minnesota Population Center, Integrated Public Use Microdata Series, International: Version 6.2 [Machine-readable database], University of Minnesota, 2013 (accessed on 23 September 2013).

Note: Data refer to census data organized in time periods centred on census rounds (plus/minus two years around 1985, 1990, 1995, 2000, 2005 and 2010).

541. As the world grows increasingly more urban, and the proportion of older persons in the global population increases, the proportionate increase in one-person households is likely to continue. Likewise, as trends in divorce are upward in several demographically large countries (India, China), and as the social acceptance of unmarried childbearing appears to be increasing, it is difficult to anticipate a forthcoming decline in the proportion of single-parent families.

542. **States, including through local municipalities, should take into consideration the growing diversity of household structures and living arrangements, and the corresponding needs for housing and communal social**

spaces for one-person households among both young and older people in order to reduce social isolation.

543. The global survey showed that three aspects of social protection systems relevant to the well-being of families and households were addressed in the previous five years by close to 80 per cent of countries: increasing efforts to ensure health, education and welfare services (85 per cent); supporting and assisting vulnerable families (84 per cent); and providing effective assistance to families and individuals (82 per cent). The proportions vary if examined by region or income. Likewise, assisting families caring for family members with disabilities and family members living with HIV was reported to have been addressed by 79 per cent of Governments in the past five years, although to a lesser extent in Oceania (33 per cent).

544. However, the global survey also indicated that providing financial and social protection schemes to single-parent families was less likely to have been addressed by Governments in the previous five years (61 per cent), despite the rise in the proportion of such households.

B. Internal migration and urbanization

1. Internal migration

545. Whether people move within or between international borders, be it permanently, temporarily or cyclically, their underlying motivations remain the same: to improve their well-being and life circumstances; to seek employment; to form, or maintain, a family. Mobility, and safety and security during internal migration, are central to the opportunity for people to secure new and better capabilities, work and livelihoods.

546. While estimates of internal migration are very challenging to obtain, analysis suggests that 740 million people worldwide live in their home country but outside their region of birth,[403] a measurement that vastly outnumbers international migration (232 million),[404] even as the great majority of global attention to mobility has been drawn to the international dimension.

547. Increasingly, women are migrating on their own or as heads of households and principal wage earners.[405] Moreover, because migration requires a range of resources, migrants do not generally come from the poorer strata of rural society,[406] except in movements forced by severe push factors such as famine, war or natural disasters.

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[403] M. Bell and S. Muhidin, *Cross-National Comparison of Internal Migration*, Human Development Research Paper No. 2009/30 (United Nations Development Programme, 2009).

[404] United Nations, "The number of international migrants worldwide reaches 232 million", *Population Facts*, No. 2013/2 (September 2013).

[405] *State of World Population 2007: Unleashing the Potential of Urban Growth* (United Nations publication, Sales No. E.07.III.H.1); C. S. Camlin, R. C. Snow and V. Hosegood, "Gendered patterns of migration in rural South Africa", *Population, Space and Place* (30 May 2013).

[406] Foresight, *Migration and Global Environmental Change: Future Challenges and Opportunities — Final Project Report* (London, Government Office for Science, 2011).

548. Mobility occurs on a continuum from voluntary migration to forced displacement. The history of severe environmental crises shows that any associated mobility is often short-term and local,[407] while displacement due to political crises or conflict may be sustained, transnational and even permanent.[408] Short- or long-term movements, whether voluntary or not, demand resources, leaving the poor more likely to be caught without resources for relocation,[406] in conditions of forced displacement or trapped in refugee sites without resources to return home. **States should support people's right to move internally as a means of improving their lives, adapting to changing social, economic, political and environmental conditions and avoiding forced displacement, and should promote, protect and provide all internal migrants with equal opportunities and access to social protection.**

549. The most significant trend in internal migration is urbanization, including both circular and permanent movements from rural areas into urban settings large and small. In fact, urban areas are expected to absorb all population growth over the next 40 years (see table 3), making this the most important spatial population trend for the coming decades. Along with migration from rural to urban areas, natural increase (the difference between births and deaths) in urban areas themselves is the other main source of urban growth.[409] The relative contribution of each factor varies considerably with time and place owing to varying levels of fertility and urbanization rates. The one factor that unites them is that increasing urbanization levels are associated with an elevation of the contribution of natural increase to urban growth, since urbanization reduces the number of potential rural-to-urban migrants while also increasing the proportion of children born in cities, despite universal lower fertility in urban areas.

Table 3

Trends and projections in urban-rural population by development group, 1950-2050

	Population (billion)					*Average annual rate of change (percentage)*			
Development group	*1950*	*1970*	*2011*	*2030*	*2050*	*1950-1970*	*1970-2011*	*2011-2030*	*2030-2050*
Total population									
World	2.53	3.7	6.97	8.32	9.31	1.89	1.55	.93	.56
More developed regions	.81	1.01	1.24	1.3	1.31	1.08	0.51	.23	.06
Less developed regions	1.72	2.69	5.73	7.03	7.99	2.23	1.85	1.07	.65
Urban population									
World	.75	1.35	3.63	4.98	6.25	2.98	2.41	1.66	1.13
More developed regions	.44	.67	.96	1.06	1.13	2.09	.89	.52	.29
Less developed regions	.3	.68	2.67	3.92	5.12	4.04	3.33	2.02	1.34

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[407] C. Tacoli, "Crisis or adaptation? Migration and climate change in a context of high mobility", in *Population Dynamics and Climate Change*, J. M. Guzmán and others, eds. (United Nations publication, Sales No. E.09.III.H.4).

[408] International Committee of the Red Cross (ICRC), *Internal Displacement in Armed Conflict: Facing up to the Challenge* (Geneva, 2009).

[409] Reclassification of rural areas as urban and changes in the definition of "urban" can also account for a variably small proportion of urban growth.

	Population (billion)					*Average annual rate of change (percentage)*			
Development group	*1950*	*1970*	*2011*	*2030*	*2050*	*1950-1970*	*1970-2011*	*2011-2030*	*2030-2050*
Rural population									
World	1.79	2.34	3.34	3.34	3.05	1.36	.87	-0.01	-.44
More developed regions	.37	.34	.28	.23	.18	-.48	-.48	-.92	-1.14
Less developed regions	1.42	2.01	3.07	3.11	2.87	1.74	1.03	.07	-.4

Source: United Nations, *World Urbanization Prospects: The 2011 Revision* (ST/ESA/SER.A/322), table 1, available from http://esa.un.org/unup/pdf/FINAL-FINAL_REPORT%20WUP2011_Annextables_01Aug2012_Final.pdf.

2. The scale and pace of urbanization

550. In 2008, for the first time, more than half of the world's population lived in the city. Between 1990 and 2010, 90 per cent of the growth in the urban population occurred in developing countries, where the urban-dwelling population increased from 35 per cent to 46 per cent. During this period, the size of the urban population in the least developed countries more than doubled, from 107 million to 234 million. Though developed countries experienced this transition earliest, Latin America also underwent a surprisingly rapid and early urban transition.[410]

551. The world's urban areas (towns and cities) are projected to gain 2.6 billion people by mid-century, growing from 3,630,000,000 people in 2011 to 6,250,000,000 2050 (see table 3). However, while the scale of this growth is enormous, the rate is actually declining. Between 1950 and 2011, the world urban population grew at an average rate of 2.6 per cent per year and increased nearly fivefold. In contrast, from 2011 to 2030, the world urban population is projected to grow at an average annual rate of 1.7 per cent.[410]

552. Meanwhile, the world rural population is projected to start decreasing in about a decade, with an expected 300 million fewer rural inhabitants in 2050 than today. Most of the anticipated population growth in urban areas will be concentrated in the cities and towns of the less developed regions, with Asia projected to see its urban population increase by 1.4 billion, Africa by 900 million, and Latin America and the Caribbean by 200 million. The sheer scale of new urban residents in the coming decades is without parallel in human history, ushering in unprecedented opportunities and challenges and requiring new and visionary responses.[410]

553. Today's 3.6 billion urban dwellers are distributed unevenly among urban settlements of varying size. As seen in figure 48, over half of the world's 3.6 billion urban dwellers (51 per cent) still live in cities or towns with fewer than half a million inhabitants. To date, the absolute growth of these smaller cities has been considerably greater than that of cities of larger size.

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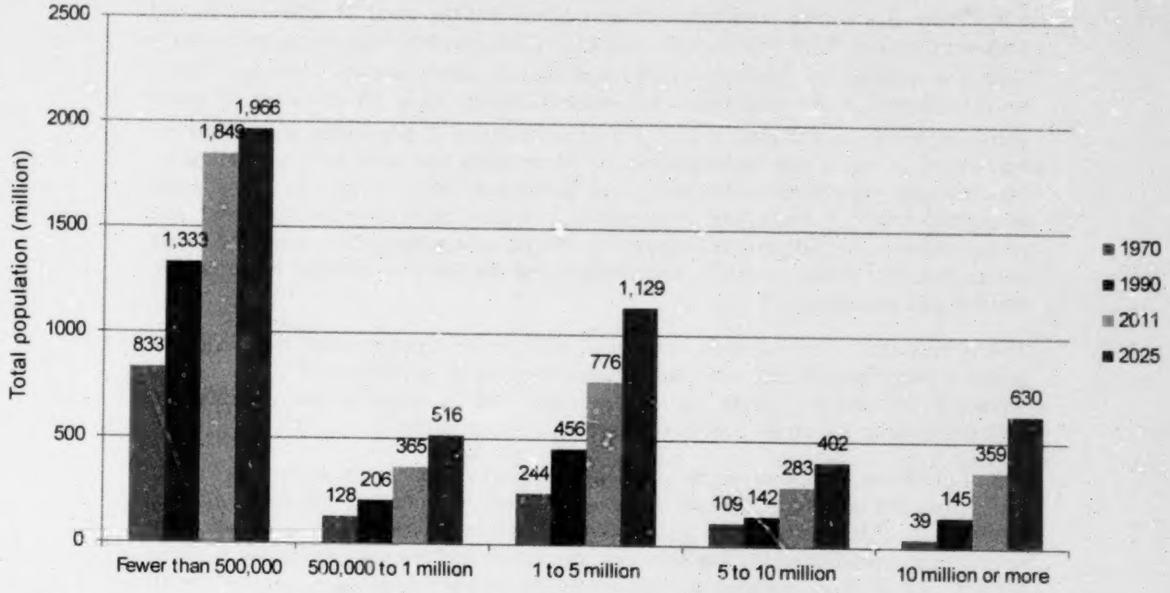
[410] *World Urbanization Prospects: The 2011 Revision* (ST/ESA/SER.A/322).

Figure 48
Distribution of world urban population by city size class, 1970-2025



Source: United Nations, *World Urbanization Prospects: The 2011 Revision* (ST/ESA/SER.A/322), figure II, available from http://esa.un.org/unup/pdf/FINAL-FINAL_REPORT%20WUP2011_Annextables_01Aug2012_Final.pdf.

554. In 2011, 23 urban agglomerations qualified as megacities, being home to at least 10 million inhabitants. Despite their visibility and dynamism, megacities account for a small, though increasing, proportion of the world urban population: just 9.9 per cent in 2011, and an expected 13.6 per cent in 2025. Furthermore, megacities are experiencing varying rates of growth, growing at higher rates in Africa and South Asia (e.g., Lagos, Dhaka and Karachi) and more slowly in Latin America.

3. Urbanization and opportunity for all

555. The Programme of Action recognized the role of cities in economic and social development, as do many of the people who are moving to urban areas in search of opportunity. Young adults account for a large proportion of urban growth. Research on urbanization in China and Bangladesh[411] highlights the appeal that urban contexts hold for young people, especially young women, who regard the move to urban areas as an opportunity to escape traditional patriarchy and experience new freedoms.[412] Even when urban housing and employment fall short of expectations and they eventually return to village life for marriage, many of these young women

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[411] A. M. Gaetano and T. Jacka, eds., *On the Move: Women in Rural-to-Urban Migration in Contemporary China* (New York, Columbia University Press, 2004); N. Kabeer, "Women, wages and intra-household power relations in urban Bangladesh", *Development and Change*, vol. 28, No. 2 (2002), pp. 261-302.

[412] Kabeer, "Women, wages and intra-household power relations in urban Bangladesh".

speak of their urban working experiences as a vital period of freedom and autonomy.[413]

556. There is a strong correlation observed between the level of urbanization and economic growth.[414] While in some countries urban poverty is growing, particularly with the arrival of migrants from rural areas, rural poverty remains higher universally.[415] Towns and cities are responsible for over 80 per cent of gross national product worldwide, a function of advantages of proximity, concentration, economies of scale and increased access to services and information technology, which create opportunities for work and entrepreneurship. They also provide the essential transport, trade and information linkages between rural, regional and global markets. In addition, demographic concentration helps reduce energy demand per capita, and makes it easier and cheaper for the State to provide basic health, welfare and education.[416]

557. Cities also offer increased autonomy, with greater opportunities for social and political participation and new paths to empowerment, as evidenced by the rise of women's movements, youth groups, political and community associations and organizations of the urban poor in developing world cities.[417]

558. Conditions in urban areas — including greater access to education, higher aspirations for children, reduced living space, and other factors favouring smaller families — contribute to lower desired fertility. In conjunction with greater access to sexual and reproductive health services, the result has been significantly reduced fertility, which has changed the trajectory of overall population growth in all countries experiencing the urban transition.[418]

559. The shape of urban growth impacts sustainability across all its dimensions. The rise of urban inequality has increased social exclusion and marginalization in cities and exacerbated urban sprawl. Along with poor public transportation infrastructure, sprawl has undermined the resource efficiencies of urban living as

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[413] L. Beynon, "Dilemmas of the heart: rural working women and their hopes for the future", in *On the Move: Women in Rural-to-Urban Migration in Contemporary China* (see footnote 411 above).

[414] UN-Habitat, *State of the World's Cities 2010/2011: Bridging the Urban Divide* (London, Earthscan, 2010).

[415] M. Ravallion, S. Chen and P. Sangraula, "New evidence on the urbanization of global poverty", Policy Research Working Paper No. 4199 (Washington, D.C., World Bank, 2007).

[416] United Nations Environment Programme (UNEP), *Towards a Green Economy: Pathways to Sustainable Development and Poverty Eradication — A Synthesis for Policy Makers* (Nairobi, 2011); United States Agency for International Development, *Sustainable Service Delivery in an Increasingly Urbanized World* (Washington, D.C., October 2013), available from www.usaid.gov/sites/default/files/documents/1870/USAIDSustainableUrbanServicesPolicy.pdf.

[417] L. Mora, "Women's empowerment and gender equality in urban settings: new vulnerabilities and opportunities", in *The New Global Frontier: Urbanization, Poverty and Environment in the 21st Century*, G. Martine and others, eds. (London, Earthscan, 2008).

[418] M. White and others, "Urbanization and fertility: an event-history analysis of coastal Ghana", *Demography*, vol. 45, No. 4 (2008), pp. 803-816; S. Goldstein and A. Goldstein, *Migration and Fertility in Peninsular Malaysia: An Analysis Using Life History Data*, Rand Note, No. N-1860-AID (Santa Monica, California, 1983); M. Brockerhoff, "Migration and the fertility transition in African cities", in *Migration, Urbanization, and Development: New Directions and Issues*, R. E. Bilsborrow, ed. (Norwell, Massachusetts, Kluwer Academic Publishers, 1998), pp. 357-390; D. Shapiro and B. O. Tambashe, "Fertility transition in urban and rural sub-Saharan Africa: preliminary evidence of a three-stage process", *Journal of African Policy Studies*, vol. 8, Nos. 2-3 (2002), pp. 103-127.

well as increased the marginalization of the poor in remote or peripheral parts of cities, often in extremely dense informal settlements with little or no open and public space.[419] The poorest urban women are often unable to access services, and may live within urban cultural enclaves in which their marital and reproductive lives, and fertility rates, are closer to those of rural women.[420] How urbanization meets the needs and aspirations of urbanizing populations, particularly the poor, is therefore greatly dependent on the choices Governments make regarding urban population growth, land, housing and infrastructure.

560. Though Governments in 1994 recognized the importance of urbanization and cities, half of them considered the spatial distribution in their countries to be unsatisfactory and in need of modification, particularly to address rapid urbanization and excessive concentration of populations in large cities. Many Governments continue to have these concerns today.[421]

561. In the global survey, when Governments were asked about urbanization issues that they had addressed in terms of policies, budgets and implementation in the preceding five years, the highest proportion of countries mentioned decentralization (74 per cent). This issue is of particular relevance to African countries, of which 85 per cent had committed to the implementation of decentralization policies, as well as to countries in Asia (9 per cent) and the Americas (73 per cent). Decentralization can have spatial, fiduciary and/or administrative aspects; each can be appropriate in the right context, though the latter two are usually considered to be two essential aspects of good governance. For many cities the decentralization of decision-making and budgeting can go a long way towards resolving urban dysfunction and providing urban residents with a stronger voice in local governance. However, decentralization can also place significant added governance responsibilities in the hands of secondary and tertiary cities, which are home to the large majority of urban residents globally yet often lack the capacity, resources and local tax bases of primary cities or megacities. Governments identified this in their responses to the global survey, with 71 per cent reporting having addressed the growth of small or medium-sized urban centres.

562. Among the most highly urbanized countries, Governments were far more likely to address "land, housing, services and livelihoods of urban poor" (71 per cent) and to report that they had been addressing "environmental management of urban agglomerations" (67 per cent) in the previous five years. These issues had been addressed by only 40 per cent of less urbanized countries, despite the fact that many are now urbanizing very quickly (by 2 per cent or more annually).

563. "Proactive planning for urban population growth" is an issue that was addressed by well over half (57.8 per cent) of countries, with higher levels prevailing in fast-growing and less-urbanized countries. This information contrasts with other data showing a steady increase in the number of developing countries that are attempting to reduce urban growth. It also contrasts with addressing the

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[419] UN-Habitat, "The relevance of street patterns and public space in urban areas", working paper (April 2013).

[420] *State of World Population 2007: Unleashing the Potential of Urban Growth* (see footnote 405 above); C. Tacoli, *Urbanization, Gender and Urban Poverty: Paid Work and Unpaid Carework in the City*, Urbanization and Emerging Population Issues, Working Paper No. 7 (International Institute for Environment and Development and United Nations Population Fund, 2012).

[421] *World Population Policies 2011* (United Nations publication, Sales No. E.13.XIII.2), table VII-3, pp. 98-99.

"integration of rural-urban migrants", which only 23 per cent of countries reported. Commitment to this issue is critical, since failure to integrate migrants into the city has been cited as one of the major factors underlying the rapid growth of slums.

4. The challenge of slums

564. Amid widespread urban growth, many Governments are presented with significant urban management concerns, including gaps in service provision, traffic congestion, poor land management and sprawl, and environmental degradation. While these challenges may affect all residents of a given city, they cause the greatest burden for the urban poor, who face enormous challenges in locating and maintaining secure housing, accessing work or public resources and achieving quality of life, as recognized by the Commission on Population and Development at its forty-sixth session in 2013, when it adopted resolution 2013/1 on new trends in migration: demographic aspects.

565. The total estimated number of global slum dwellers has risen from over 650 million in 1990 to about 820 million in 2010.[422] Almost 62 per cent of the urban population in sub-Saharan Africa lived in housing designated as slums in 2010, the highest of any region in the world by a large margin.

566. But slum growth should not be conflated with urbanization, as urban population growth and urban slum growth are two distinct phenomena. The majority of evidence suggests that global urbanization is an inevitable trend, though it takes place at different rates in distinct places. Slum populations, on the other hand, have declined as a proportion of the total urban population, even in sub-Saharan Africa, where 70 per cent of the population in urban areas in 1990 were in housing designated as slums. Slum growth is, in a significant way, an outcome of governance decisions to limit access to the city for the poor, by limiting service provision to informal settlements or by forced evictions and resettlement of the urban poor to peripheral or underserviced areas.

567. The vulnerability of people, especially women, in many urban areas today reflects the absence of proactive, innovative planning for the provision of safe housing, adequate health services, reliable transport to the economic centre and protection from violence, as well as community systems of social protection. **States, including through local municipalities, should fulfil the need for public housing; provide for affordable housing and the development of infrastructure that prioritizes the upgrading of slums and the regeneration of urban areas; and commit to improving the quality of human settlements so that all people have access to basic services, housing, water and sanitation, and transportation, with particular attention to security and safety, especially to prevent gender-based violence.**

568. Yet despite the numerous stresses within urban slums, including evidence of heightened violence and risk within informal urban settlements,[423] urban centres continue to attract rural populations, especially young adults, in developing countries, as they seek greater economic opportunities and social freedom. This is why, despite

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[422] UN-Habitat Global Slum Estimates, 2012. Comprising population living in households that lack either improved water, improved sanitation, sufficient living area (more than three persons per room), or durable housing.

[423] R. Muggah, *Researching the Urban Dilemma: Urbanization, Poverty and Violence* (Ottawa, International Development Research Centre, 2012).

anti-urban policies and widespread attention to lowering urban growth rates around the world, urbanization persists.

Human rights elaborations since the International Conference on Population and Development

Box 20

Water and sanitation

Intergovernmental human rights outcomes. In resolution 64/292 on the human right to water and sanitation (2010), the General Assembly recognized "the right to safe and clean drinking water and sanitation as a human right that is essential for the full enjoyment of life and all human rights". Subsequently, the Human Rights Council, in resolution 15/9 on human rights and access to safe drinking water and sanitation (2010), affirmed that the right to water and sanitation was derived from the right to an adequate standard of living.

Other soft law. In general comment No. 15 on the right to water (2002) the Committee on Economic, Social and Cultural Rights explained that the right to water is implicit in articles 11 and 12 of the International Covenant on Economic, Social and Cultural Rights, which protect the right to an adequate standard of living, and the right to health. The draft guidelines for the realization of the right to drinking water and sanitation (2005) are "intended to assist government policymakers, international agencies and members of civil society working in the water and sanitation sector to implement the right to drinking water and sanitation".

5. The importance of urban-rural links: strengthening the health system

569. At the lowest income levels, health indicators for poor urban residents are often equivalent to or worse than those for their rural counterparts, and far below those for the urban well-to-do. A review of rural and urban maternal health care across 23 African countries in the 1990s found that while on average the urban poor received better antenatal and delivery care than rural residents, the disadvantage of the urban poor was more notable in countries where maternal health care was somewhat better.[424] In short, where health sectors are least effective, rural and urban care suffers to a similar degree, but where resources have strengthened care, the urban middle and upper class have gained disproportionately.

570. For the urban poor, health services are routinely overcrowded and often staffed by overstretched health workers. With the rise of unregulated private providers in urban areas, poor urban residents may have to pay for services that are delivered free of charge at public health posts in rural areas. For those living in slums, health-seeking can require long travel to facilities located on the outskirts of slums, and transport and cost can both act as barriers to care. The urban poor often receive poorer-quality services in both public and private-sector facilities compared to wealthier urban residents. The urban poor also face unhealthy and often risky living

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[424] M. Magadi, E. Zulu and M. Brockerhoff, "The inequality of maternal health care in urban sub-Saharan Africa in the 1990s", *Population Studies*, vol. 57, No. 3 (2003), pp. 347-366.

conditions that can contribute to poor health outcomes. Ultimately, the "urban health advantage" masks disparities between poorer and wealthier urban areas.[425]

571. In most countries health workers are already disproportionately concentrated in urban areas,[426] although not necessarily serving the urban poor.[427] To avoid neglect of rural areas, innovations are needed to ensure that urban investments also benefit rural areas, for instance through health worker rotations, new uses of mobile technologies and other rural-urban health system linkages.[428] These innovations also need to move outside the traditional boundaries of the health system, to develop transport, resource and financial linkages between rural and urban areas that facilitate connections and reduce inequality across the spatial divide. A major challenge for the coming decades is the creation and evaluation of such innovative health system structures, responding to urban growth in a way that also encourages investments in rural care.

572. **States should promote development that will foster and facilitate linkages between urban and rural areas, in recognition of their economic, social and environmental interdependence, including the development and equitable distribution of satellite and nodal centres of excellence in health, education,**

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[425] Z. Matthews and others, "Examining the 'urban advantage' in maternal health care in developing countries", *PLoS Medicine*, vol. 7, No. 9 (2010); J. C. Fotso, A. Ezeh and R. Oronje, "Provision and use of maternal health services among urban poor women in Kenya: what do we know and what can we do?", *Journal of Urban Health*, vol. 85, No. 3 (2008), pp. 428-442; M. R. Montgomery, "Urban poverty and health in developing countries", *Population Bulletin*, vol. 64, No. 2 (2009); J. C. Fotso and others, "What does access to maternal care mean among the urban poor? Factors associated with use of appropriate maternal health services in the slum settlements of Nairobi, Kenya", *Maternal and Child Health Journal*, vol. 13, No. 1 (2009), pp. 130-137; V. N. Salgado de Snyder and others, "Social conditions and urban health inequalities: realities, challenges and opportunities to transform the urban landscape through research and action", *Journal of Urban Health: Bulletin of the New York Academy of Medicine*, vol. 88, No. 6 (2011); K. Ghei and others, "Association between child immunization and availability of health infrastructure in slums in India", *Archives of Pediatrics and Adolescent Medicine*, vol. 164, No. 3 (2010), pp. 243-249; L. Hulton, Z. Matthews and R. W. Stones, "Applying a framework for assessing the quality of maternal health services in urban India", *Social Science and Medicine*, vol. 64, No. 10 (2007), pp. 2083-2095; J. Das and J. Hammer, "Money for nothing: the dire straits of medical practice in Delhi, India", *Journal of Development Economics*, vol. 83, No. 1 (2007), pp. 1-36; J. Das and J. Hammer, "Location, location, location: residence, wealth and the quality of medical care in Delhi, India", *Health Affairs*, vol. 26, No. 3 (2007), pp. 338-351; J. C. Fotso, "Child health inequities in developing countries: differences across urban and rural areas", *International Journal for Equity in Health*, vol. 5, No. 9 (2006).

[426] L. Chen and others, "Human resources for health: overcoming the crisis", *The Lancet*, vol. 364, No. 9449 (2004), pp. 1984-1990; WHO, "Achieving the health related MDGs: it takes a workforce" (www.who.int/hrh/workforce_mdgs/en/index.html); G. Dussault and M. C. Franceschini, "Not enough there, too many here: understanding geographical imbalances in the distribution of the health workforce", *Human Resources for Health*, vol. 4, No. 2 (2006).

[427] Matthews and others, "Examining the 'urban advantage' in maternal health care in developing countries"; Montgomery, "Urban poverty and health in developing countries" (see footnote 425 above).

[428] V. Govindarajan and R. Ramamurti, "Delivering world-class health care, affordably", *Harvard Business Review*, November 2013; S. B. Syed and others, "Developed-developing country partnerships: benefits to developed countries?", *Globalization and Health*, vol. 8, 2012; J. A. Effken and P. Abbott, "Health IT-enabled care for underserved rural populations: the role of nursing", *Journal of the American Medical Informatics Association*, vol. 16, No. 4 (2009), pp. 439-445.

business, transportation and communications, to promote mobility, opportunity and economic growth for those residing in urban centres, small and medium towns and rural areas alike.

573. Given the urban growth expected in the coming decades, coupled with the enormous reliance on urban areas for poverty reduction, economic growth and environmental sustainability, multisectoral leadership in urban planning is a growing need, nationally and globally.

574. Securing available and affordable land and housing is crucial to ensure housing security for the urban poor in contexts of rapid urban growth; as more people come to urban areas, space constraints and inequality in the distribution of land tend to produce rapidly increasing costs of living, with the elite capturing the most accessible and desirable land.[429]

575. The most significant policy challenge in the context of urbanization is not to change its trajectory, but to identify ways to extend the full set of potential benefits of urban life to all current and future urban residents, and to do so in ways that can also link urban-rural development.

Case study — Sustainable urbanization

Ecuador

Preparing for urban expansion: access to residential land for the urban poor[430]

Ecuadorian cities are no exception to urban expansion, and while currently there is undeveloped land available for residential development, there are serious shortages of serviced urban land for low-income housing in the formal sector. This has led to a great deal of land subdivision and sale in the informal sector, either through land invasions or through informal land subdivisions that do not conform to zoning and subdivision regulations. Compared with other countries, a very high percentage of urban households in Ecuador live in unauthorized housing communities without legal title documents.

In order to guarantee that residential land for the urban poor will remain affordable, municipalities must ensure that accessible urban land remains in ample supply in the coming years, so that land prices will not be subject to speculative increases.

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[429] UN-Habitat, "Land in support of sustainable urbanization", backgrounder prepared for the Third African Ministerial Conference on Housing and Urban Development, Bamako, 22-24 November 2010.

[430] Based on S. Angel, "Preparing for urban expansion: a proposed strategy for intermediate cities in Ecuador", in *The New Global Frontier: Urbanization, Poverty and Environment in the 21st Century*, G. Martine and others, eds. (London, Earthscan, 2008).

To this end, seven intermediate-sized municipalities in Ecuador that are currently experiencing rapid urban growth have started delimiting new expansion areas based on preliminary population and built-up area projections, planning the arterial road networks in the new expansion areas, refining legal tools for acquiring the rights of way for the arterial road networks and estimating the budgets needed for implementation. If carried out early enough, this strategy will involve a relatively low amount of investment and has a potentially high rate of return in economic, social, demographic and environmental terms.

Capitalizing on urbanization[431]

First step: accept urbanization as a part of the development process

- Political opposition to urban growth has little impact on slowing it but infringes on individual rights, and can make both urban and rural poverty worse. When migrants make a choice to move to the city, they are making a rational choice to improve their lives and reduce their vulnerability.
- Once policymakers accept the inevitability of urban growth, they are in a position to improve their cities and the lives of their present and future residents.

Second step: plan for growing cities in the context of rural-urban links

- The major issues that affect cities throughout the world — housing, transportation, environment, water, sanitation and energy, among others — all require a coordinated regional approach that cuts through fragmented boundaries and includes both peri-urban and rural areas. Rural development and urban development are not contradictory but instead reinforce each other, particularly given that many people have dual residence.

Third step: promote the sustainable use of space

- Work openly and transparently with communities and the private sector to develop a participatory vision of where and how the city should grow.
- Promote urban growth within a systematic concern for environmental values.
- Minimize the size and impact of the urban blight through policies to limit sprawl.
- Set aside land for public space.
- Favour energy-saving and well-integrated mass transportation.
- Favour density, compactness and effective links between agglomerations.

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[431] Based on *State of World Population 2007: Unleashing the Potential of Urban Growth* (see footnote 405 above).

Fourth step: promote the social use of space

- Improve slum areas in situ, focusing on mixed-use construction and housing solutions that can expand over time as households grow.
- Improve functioning of land markets and reinvest taxes charged on capital gains from urban land speculation in land banks for the future.
- Develop supports for land, housing and services for the urban poor; their integration and prospects for dignity and livelihoods are vital to the ongoing success of cities.

6. Government priorities: internal migration and urbanization

Improving the quality of urban life	51 per cent of Governments
Develop urban planning programmes, policies, laws and institutions	48 per cent of Governments
Develop and promote small and medium urban centres	32 per cent of Governments
Social protection	32 per cent of Governments
Environmental management	23 per cent of Governments

576. National priorities pertaining to spatial distribution, internal mobility and urbanization can be understood across two critical dimensions aligned with the nature of urban growth and its intersection with both urban and rural development. The first focuses on whether the Government places greater emphasis on improving urban centres, small and medium urban areas, or rural areas. Among these, Governments responding to the global survey were far more likely to give priority to "improving the quality of urban life" (51 per cent of Governments mentioned this among their top five priorities), while fewer mentioned "develop and promote small and medium-sized urban centres" (32 per cent), or "rural development"[432] (16 per cent). Almost 30 per cent of countries in Asia indicated that rural development was a priority, but just 2 of 30 Governments in the Americas (where the urban transition is essentially complete) did so.

577. The second dimension concerns whether Governments prioritized recognition of "population dynamics related to urbanization" — urban population growth, sprawl or concentration; internal migration out of rural areas or into urban areas (14 per cent of Governments) — or whether they prioritized "efforts to influence the spatial distribution of the population or prevent urbanization" (21 per cent of Governments). A relatively greater proportion of Governments in Africa (27 per cent) and Asia (29 per cent), where rapid urbanization is currently taking place, prioritized the latter.

578. Governments consistently prioritized "development of urban planning policies, programmes and strategies and the creation of laws and institutions" associated with

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[432] Refers to all priorities related to rural development, including addressing disparities between rural and urban areas, but excluding those with the stated intention of keeping people in rural areas.

urbanization (48 per cent), as well as "social protection" (32 per cent) and "environmental management" (23 per cent). Asian Governments were more likely to be concerned about environmental management linked to urban areas, with 34 per cent identifying it as a priority. Social protection was the third most frequently mentioned priority in the Americas, with 40 per cent of Governments identifying it.

579. **States should capitalize on the opportunities that urbanization provides for sustainable development and undertake proactive participatory planning to harness the benefits of higher population density in urban areas, recognizing the significant impact that greater internal migratory flows have on the distribution and concentration of populations in cities, notably higher energy efficiency in transport and housing, as well as cheaper provision of health, communications and other basic services per capita.**

C. International migration

580. The total estimated number of international migrants[433] in the world increased from 154 million in 1990 to 232 million in 2013, and its continued rise is expected into the foreseeable future. Although this represents an increase in the number of migrants, the percentage of international migrants in the global population has changed only slightly in the 23-year period, from 2.9 per cent in 1990 to 3.2 per cent in 2013. The percentage of all international migrants living in developed countries increased from 53 per cent in 1990 to 59 per cent in 2013, when international migrants represented 10.8 per cent of the total population in developed countries, compared with 1.6 per cent of the total population in developing countries.[434]

581. Contemporary patterns of international movement are significantly more complex than those of the past, not only because of the sheer numbers of international migrants, but also because the flows are now truly global. The growth and diversification of migration patterns have meant that an increasing number of countries are affected by migration, and that most countries are now concurrently countries of origin, destination and transit. In 2010, of the 43 countries hosting at least 1 million immigrants, 24 were the places of origin of more than 1 million emigrants. Countries that experienced large gains in numbers of migrants between 1990 and 2010, such as Malaysia, Nigeria and Thailand, also experienced a large increase in the number of their citizens living abroad.[435]

582. Additionally, the composition of migration flows is changing in a number of ways. Today's migrants come from a broader spectrum of economic, social and cultural backgrounds than ever before. Among international migrants worldwide today, approximately half are women (48 per cent) — 52 per cent in developed

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[433] The data presented here refer to the international migrant stock defined as a mid-year estimate of the number of people living in a country or area other than the one in which they were born or, in the absence of such data, the number of people of foreign citizenship. Most statistics used to estimate the international migrant stock were obtained from population censuses, population registers and nationally representative household surveys. The estimates of the migrant stock were prepared by the Population Division of the Department of Economic and Social Affairs of the United Nations Secretariat.

[434] United Nations, "The number of international migrants worldwide reaches 232 million" (see footnote 404 above).

[435] Report of the Secretary-General on new trends in migration: demographic aspects (E/CN.9/2013/3).

countries and 43 per cent in developing countries.[434] Since women often live longer than men, they tend to be overrepresented among older migrants. The large guest worker programmes in Europe in the 1950s, 1960s and the early 1970s were male dominated.[436] Changes in the migratory behaviour of women became apparent in the 1980s and 1990s with the development of service sector employment and, in particular, the growing need for nurses, teachers and domestic workers.[437] Women are now likely to migrate on their own or as heads of households.[438]

583. The median age of international migrants is estimated to be 38.4 years, compared with 29.2 years in the total population. International migrants tend to be older than their non-migrating counterparts, especially because children born to persons born abroad are included in the native-born population.[439] However, immigration flows to selected European countries (Denmark, Germany, Italy, the Netherlands, Norway, Slovenia and Sweden) for the years 2008 and 2009 suggest that a high proportion of the foreigners entering a country as migrants in any given year are concentrated in the younger adult ages.[440] In these countries, on average, two out of every five newly arriving migrants are aged 18-29.

1. Regional differentials in international migration

584. In 2013, there was as much international migration between developing countries as there was from developing to developed countries. About one third of global migrants (82.3 million people, or 36 per cent) both originated from and were living in a developing country in 2013. Another third of the total number of global migrants (81.9 million people, or 35 per cent) were born in a developing country but resided in a developed country. Further, about one quarter of all international migrants in the world (53.7 million people, or 23 per cent) were born and were living in a developed country. The percentage of international migrants who were born in a developed country and were now living in a developing country stood at only 6 per cent (13.7 million people).[441]

585. While migration from developing to developed countries has been the main driver of global migration trends, doubling from 40 million in 1990 to 81.9 million in 2013 and growing more than twice as fast as the global total, migration between developing countries remains the largest kind of migratory movement, involving 82.3 million people.[441]

586. Major regions of the world account for different shares of migrants (see figure 49). For example, in 2013, Europe hosted 31 per cent of the total number of

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[436] P. Martin, "Managing labor migration: temporary worker programmes for the 21st century", paper prepared for the International Symposium on International Migration and Development, held in Turin, Italy, from 28 to 30 June 2006.

[437] ILO, "Women and men migrant workers: Moving towards equal rights and opportunities" (2008); available from www.ilo.org/wcmsp5/groups/public/@dgreports/@gender/documents/publication/wcms_101118.pdf.

[438] *State of World Population 2007: Unleashing the Potential of Urban Growth* (see footnote 405 above).

[439] United Nations, "International migration 2013: age and sex distribution", *Population Facts*, No. 2013/4 (September 2013).

[440] United Nations, Population Division, "International migration in a globalizing world: the role of youth", Technical Paper No. 2011/1 (New York, 2011).

[441] United Nations, "International migration 2013: migrants by origin and destination", *Population Facts*, No. 2013/3 (September 2013).

migrants, whereas it was the region of origin of 25 per cent of all emigrants (of whom 65 per cent were also living within Europe). In comparison, Asia and North America hosted 31 per cent and 23 per cent of the total number of migrants respectively, while they were the region of origin of 40 and 2 per cent of all emigrants. Furthermore, the majority of international migrants from Europe (65 per cent), Asia (58 per cent) and Oceania (58 per cent) were living in a country within their region of birth (58 per cent in both cases), whereas the majority of international migrants born in Latin America and the Caribbean (85 per cent), North America (72 per cent) and Africa (51 per cent) were residing in a country outside their region of birth.[441]

Figure 49

International migrants by major area of origin and destination, 2013

(Millions)

		Origin								
		Africa	*Asia*	*Europe*	*Latin America and the Caribbean*	*North America*	*Oceania*	*Various*	*Total*	*Per cent destination*
Destination	Africa	15.3	1.1	0.8	0.0	0.1	0.0	1.4	**18.6**	82
	Asia	4.6	53.8	7.6	0.7	0.6	0.1	3.4	**70.8**	76
	Europe	8.9	18.6	37.8	4.5	0.9	0.3	1.3	**72.4**	52
	Latin America and the Caribbean	0.0	0.3	1.2	5.4	1.3	0.0	0.2	**8.5**	64
	North America	2.0	15.7	7.9	25.9	1.2	0.3	0.0	**53.1**	2
	Oceania	0.5	2.9	3.1	0.1	0.2	1.1	0.1	**7.9**	14
	Total	**31.3**	**92.5**	**58.4**	**36.7**	**4.3**	**1.9**	**6.4**	**231.5**	
	Per cent origin	49	58	65	15	28	58			

Source: United Nations, Population Facts No. 2013/3, "International migration 2013", table 1.

587. International migration flows have become increasingly diversified over the past 20 years, with countries such as Mexico, China, India and the Russian Federation emerging as important places of origin and destination. Millions of international migrants reside in India, whereas, for instance in 2013, some 2.9 million international migrants from India were residing in the United Arab Emirates and 1.8 million in Saudi Arabia. Likewise, the United States of America hosted some 13 million persons born in Mexico, 2.2 million born in China, 2.1 million from India and 2 million from the Philippines. Finally, bilateral flows of international migrants are especially large for Kazakhstan, the Russian Federation and Ukraine.[441]

588. One result of low fertility rates and ageing populations is labour shortages at all skill levels, and the need for skilled care for older persons in ageing societies

will increase in the coming decades.[442] These trends are already easily identifiable in many developed countries and can be foreseen in many developing countries, especially those that have seen unprecedented rates of economic growth in recent decades.[443] At the same time, many developing countries still experience a mismatch between the number of young, working-age people and the absorptive capacities of their labour markets.[444] As a consequence, while migration flows (particularly labour migration) are primarily due to economic conditions and inequalities, they can also be explained by demographic imbalances reflected in labour force surpluses and deficits. Migration already contributes to population growth in many countries, but the long-term demographic outcome of migration will vary depending on the composition of the migrant population and on whether movement is temporary, long term or permanent; whether it coincides with childbearing or child-rearing in the country of destination; and whether migrant children are granted citizenship and adopt the new country as their own.[445]

589. Migration is a key enabler for social and economic development in countries of origin and destination.[446] It is also an important vehicle for the human development of migrants and their families, enlarging their capabilities, opportunities and choices that can improve their lives and those of their family members. **States should embrace the contributions migration makes to the political, economic, social and cultural fabric of countries of origin and destination alike, as well as to the global community, and should build better systems for monitoring the development benefits of migration.**

590. Financial transfers in the form of remittances sent by migrants to their home countries and networks exceed official development assistance and constitute the largest single source of financial flows to some developing countries, exceeding at times foreign direct investment flows. These transfers, which reached US$ 401 billion in 2012 (not counting flows through informal channels),[447] can have positive development impacts on countries of origin. They supplement the family income, directly improving the quality of life, lifting families out of poverty, increasing access to education and health services and, through their multiplier effects, may generate income and employment in the wider economy.

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[442] F. Mullan, S. Frehywot and L. J. Jolley, "Aging, primary care, and self-sufficiency: health care workforce challenges ahead", *Journal of Law, Medicine and Ethics*, vol. 36, No. 4 (2008), pp. 703-708; B. Rechel and others, "How can health systems respond to population ageing?", *Policy Brief*, No. 10 (Copenhagen, WHO Regional Office for Europe, 2009); University at Albany, Center for Health Workforce Studies, "The impact of the aging population on the health workforce in the United States: summary of key findings" (March 2006), available from www.albany.edu/news/pdf_files/impact_of_aging_excerpt.pdf.

[443] D. E. Bloom, D. Canning and G. Fink, "Implications of population aging for economic growth", Program on the Global Demography of Aging, Working Paper No. 64 (Harvard School of Public Health, January 2001), available from http://diseaseriskindex.harvard.edu/pgda/WorkingPapers/2011/PGDA_WP_64.pdf.

[444] ILO, *Global Employment Trends for Youth 2013: A Generation at Risk* (Geneva, International Labour Office, 2013).

[445] IOM, "Economic cycles, demographic change and migration", background paper prepared for the International Dialogue on Migration 2011; available from www.iom.int/jahia/webdav/shared/shared/mainsite/microsites/IDM/workshops/economic-cycles-demographic-change/Background-Paper-EN.pdf.

[446] See E/CN.9/2013/3 (see footnote 435 above).

[447] World Bank, *Migration and Development Brief*, No. 20 (19 April 2013).

591. Migrants are also important for transmitting "social remittances" to their countries of origin,[448] including new ideas, products, information and technology, and diasporas play an important role in establishing academic and business networks between countries of origin and destination.

592. There are also social costs of migration, including for children and the elderly who remain in the country of origin, as well the challenge of emigration of skilled professionals from developing countries ("brain drain"). Migration of highly educated and highly skilled segments of the population can be a loss to sending countries of much-needed talent, and may hinder the implementation of national development strategies. In 2006, the global shortage of health workers was estimated at 4.3 million, including 2.4 million doctors, nurses and midwives. Among the 57 countries facing a critical shortage of doctors and nurses, 36 were situated in sub-Saharan Africa. Several countries have implemented voluntary codes to limit the recruitment of health workers from countries experiencing severe shortages of doctors and nurses. In 2010, the World Health Assembly adopted a global code of practice to guide member States in the recruitment of health workers. While affirming the right of health professionals to seek employment in other countries, the code discourages member States from actively recruiting health personnel from developing countries that face critical health worker shortages and promotes international cooperation regarding the development of the national health workforce.[449]

593. The Programme of Action of the International Conference on Population and Development was a landmark for international migration, recommending increased policy coherence and calling on Governments of countries of origin and destination to seek to make the option of remaining in one's country a viable one for all people. At the Millennium Summit of the United Nations, world leaders agreed, inter alia, to ensure respect for, and protection of, the human rights of migrants, migrant workers and their families.

594. In the global survey, the issue of international migration that Governments most frequently reported addressing over the previous five years was "trafficking and/or smuggling of migrants" (65 per cent). Regionally, this topic was addressed by a consistently large proportion of countries in Europe (71.4 per cent), the Americas (70 per cent), Asia (69.7 per cent) and Africa (65.1 per cent), but few in Oceania (11 per cent). Some 60 per cent of countries reported "protecting migrants against human rights abuses, racism, ethnocentrism and xenophobia" (60.4 per cent). This issue was addressed by a higher proportion of countries in the Americas (70 per cent) and Asia (70.6 per cent), compared with those in Africa (56.5 per cent), Europe (58.6 per cent) or Oceania (20 per cent).

595. As the number of international migrants continues to rise, destination countries are confronted with the challenge of promoting social, political and economic integration. Integration is often best achieved at a young age, underscoring the importance of education, services and full participation for young migrants.[450] Racism and xenophobia, fuelled by the global economic crisis, have strained

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[448] P. Levitt and D. Lamba-Nieves, "Social remittances reconsidered", *Journal of Ethnic and Migration Studies*, vol. 37, No. 1 (2011), pp. 1-22.

[449] United Nations, "Health workers, international migration and development", *Population Facts*, No. 2010/2/E/Rev (August 2010).

[450] See report of the Commission on Population and Development on its forty-sixth session (E/2013/25).

relations between immigrant and non-immigrant communities in a number of countries.

596. **Greater efforts should be made to promote and protect the human rights and fundamental freedoms of international migrants, regardless of their migration status, especially women, young people and children, and provide social protection to all migrants, including from illegal or violent acts, including acts of discrimination and crimes perpetrated on any basis, and to protect their physical integrity, dignity, religious beliefs and cultural values.**

Human rights elaborations since the International Conference on Population and Development

Box 21

International migration

Binding instruments. The International Convention on the Protection of the Rights of All Migrant Workers and Members of Their Families (1990), which entered into force in 2003, ensures fundamental human rights protections and principles for migrant workers and their families. The Protocol against the Smuggling of Migrants by Land, Sea and Air, supplementing the United Nations Convention against Transnational Organized Crime (2000; entry into force 2004) "prevent[s] and combat[s] the smuggling of migrants ... while protecting the rights of smuggled migrants".

Other soft law. General comment No. 1 on migrant and domestic workers (2011) adopted by the Committee on the Protection of the Rights of all Migrant Workers and Members of Their Families highlights the multifaceted vulnerabilities of domestic migrant workers and their risks throughout the migration cycle. Further, general comment No. 2 on the rights of migrant workers in an irregular situation and members of their families (2013) focuses on the unique vulnerabilities of international migrants in an irregular situation and their families, and clarifies the normative framework for the protection of their rights under the International Convention.

597. Over 69 per cent of countries reported that they had addressed "issues related to international migration and development" by creating institutions and programmes, policies and/or strategies. This percentage is as low as 39 per cent in Oceania and 61 per cent in Europe, but it exceeds 81 per cent in Asia. In the case of the Americas, 75 per cent of countries had addressed these issues, while in Africa 70 per cent of countries had done so.

598. A smaller proportion of countries had addressed the issue "strengthening of dialogue and cooperation between countries of origin, transit and destination" (54 per cent). Although no remarkable differences are observed by region or population growth, this issue was addressed by a higher proportion of wealthier countries. A similar proportion of countries focused their efforts on "strengthening support for international activities to protect and assist refugees and displaced persons" (56 per cent). Although this issue also grows in relevance as countries develop, there are

large differences between high-income OECD countries (91 per cent) and high-income non-OECD countries (11 per cent). About one third of countries in Europe had not addressed this issue, while in the case of Africa, the Americas and Asia this percentage increased to between 42 per cent and 50 per cent. In Oceania, 8 out of 13 countries, or 67 per cent, had not addressed it.

599. **States should address international migration through increased international, regional or bilateral cooperation and dialogue and shared responsibility, with a comprehensive and balanced approach to ensure orderly, regular and safe processes of migration, recognizing the roles and responsibilities of countries of origin, transit and destination, and promoting policies that foster the integration and reintegration of migrants and ensure the portability of acquired benefits from work abroad and migration.**

600. Fewer than half of the responding countries reported addressing "the root causes of migration and [making] remaining in one's country a viable option for all people" (35 per cent), or facilitating "the flow and use of remittances to support development" (42 per cent). In relation to the latter, Africa was the only region where half of the countries addressed the issue (52 per cent), as the proportion decreased in the Americas (45 per cent), Asia (43 per cent), Europe (27 per cent) and Oceania (25 per cent). A detailed subregional analysis illustrates differences among the American subregions (Caribbean, 33 per cent; Central America, 57 per cent; South America, 50 per cent) as well as in the European ones (Western Europe, 100 per cent; Southern Europe, 10 per cent; Northern Europe, 20 per cent, Eastern Europe, 14 per cent). Income and population growth analysis show that this issue was addressed by a higher proportion of poor and fast-growing countries.

601. Finally, only 23 per cent of countries addressed "the factors that contribute to forced internal displacement", but global and regional frequencies might have been distorted as countries where the issue was not applicable might have responded "no" (there was no "not applicable" option available in the questionnaire). Most countries that addressed this issue are located in Africa (12), Asia (10) and Europe (6).

2. Government priorities: international migration

Development of migration programmes, policies, laws and institutions	46 per cent of Governments
Capacity strengthening of research and data systems	35 per cent of Governments
Maximizing social inclusions and rights of migrants	32 per cent of Governments
International cooperation	28 per cent of Governments
Trafficking	23 per cent of Governments

602. When Governments were asked to identify policy priorities related to international migration for the next five years, the most frequently listed issues were closely aligned with the most critical aspects of migration policy for development and for migrant support, including the development of migration programmes, policies, laws and institutions; strengthening the capacity of research and data systems; maximizing social inclusion and the rights of migrants; international cooperation between Governments of origin, destination and transit; and trafficking.

603. A significant portion of international migration occurs beyond the ability of Governments to track or shape it. This is the case for both irregular migration (which, together with border control, was a priority of 23 per cent of Governments) and regular migration, which can slip through spotty and insufficient observation systems. Lack of sufficient migration data is a recognized challenge around the world, and was a priority for one third (35 per cent) of all Governments.

604. Perhaps as a result of these complexities, creating national governance functions associated with international migration was a priority for almost half of all Governments (46 per cent), across all regions and among four of five income groups (except for high-income non-OECD countries). As regards international cooperation, formal mechanisms of international governance around migration are still relatively new, yet 28 per cent of countries considered such international interactions an important priority for preparing for, and managing, flows of migrants.

605. Social inclusion and rights incorporate the integration, equal treatment, empowerment and rights of international migrants in society. This issue was a priority among countries in the Americas (40 per cent) and Europe (43 per cent), as well as among high-income OECD Governments, 11 of 19 of which listed it. Trafficking, a topic that was frequently mentioned as having been addressed over the previous five years, was listed as a future priority for only 23 per cent of Governments; this was relatively balanced across regions.

606. Despite the common focus on international migration as a labour market issue, remittances were listed as only the eleventh priority globally,[451] although they were mentioned by more African Governments (27 per cent). African Governments also frequently prioritized both promotion of investment among diaspora communities (41 per cent) and reducing emigration by creating favourable conditions and preventing brain drain (25 per cent), issues that received significantly less attention in other regions.

607. One issue of critical important for international migration, particularly for very specific countries that may be existentially threatened, is the link with climate change impacts. Kiribati listed as its first priority its efforts to gain support from the international community to take on workers from Kiribati as part of its strategy for climate change adaptation; it asked whether other Governments would take in workers from Kiribati if they were trained and equipped to international standards. Kiribati highlighted that international law did not recognize people displaced by climate change as refugees, and it is searching for options should climate change in the country reach the point where nationals are required to look for alternate homes.

D. Insecurity of place

608. One of the most basic of needs — a foundational aspect of human security — is land and housing security. Vast numbers of people around the world go to sleep every night without a roof over their heads or without the assurance that they will have one the next day. Land and housing insecurity exacerbates multiple other insecurities, including income, food, legal status, safety and/or health, posing a critical threat to the individual's dignity, to personhood in the eyes of the State, and to community cohesiveness.

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[451] Remittances are vitally important for some countries, and not very important for others, meaning that this particular priority may not lend itself to a global or regional analysis.

609. The Programme of Action recognized causes of displacement ranging from environmental degradation to natural disasters and internal conflicts that destroy human settlements and force people to flee from one area of a country to another. It focused on women's increasing vulnerability to violence in situations of displacement, as well as the heightened risk of displacement for indigenous peoples. The right of voluntary and safe return was a key focus, as were basic services, including sexual and reproductive health services, during displacement.

610. Across the spectrum of land and housing insecurity, invisibility in the eyes of the State is a common challenge owing to a severe lack of data, which hinders both estimates of the scale of those impacted and the implementation of effective measures to assist them. One of the challenges for the next 5-10 years is to understand the scale and characteristics of populations facing such vulnerabilities, and to craft more humane programmes of support.

Human rights elaborations since the International Conference on Population and Development

Box 22
Housing

Other soft law. The right to adequate housing is enshrined in article 11 of the International Covenant on Economic, Social and Cultural Rights (1966; entry into force 1967) and further elaborated in general comment No. 4 on the right to adequate housing (1991) adopted by the Committee on Economic, Social and Cultural Rights. The first Special Rapporteur on adequate housing as a component of the right to an adequate standard of living was appointed by the Commission on Human Rights in resolution 2000/9. The Special Rapporteur defined "the human right to adequate housing [as] the right of every woman, man, youth and child to gain and sustain a safe and secure home and community in which to live in peace and dignity" (E/CN.4/2001/51, para. 8). Numerous international human rights instruments adopted after 1993, as well as general comments and recommendations of the treaty monitoring bodies, have emphasized the right to housing and the interrelationship of housing with other basic human rights.[452]

1. Women's access to land

611. One of the most widespread forms of land insecurity is lack of ownership rights. While most countries allow widespread property ownership, and many do not legally differentiate between men and women as property owners, in practice enormous numbers of women are denied their right to land ownership. Whether in rural areas of developing countries, where they produce most of the food but hold

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[452] See, for example, article 28 of the Convention on the Rights of Persons with Disabilities (United Nations, *Treaty Series*, vol. 2515, No. 44910), and general comments No. 7 (1997), No. 14 (2000) and No. 15 (2002) of the Committee on Economic, Social and Cultural Rights (see E/1998/22, E/2001/22 and E/2003/22).

title to almost no land,[453] or in urban areas, where households headed by women are common and formal land ownership is particularly scarce for the poor,[454] enormous numbers of women lack the security of home and livelihood for which land tenure and property rights are so critical.

612. In the Programme of Action Governments committed to ensure that women could buy, hold and sell property and land equally with men; obtain credit and negotiate contracts in their own name and on their own behalf; and exercise their legal right to inheritance.

613. Results of the global survey indicate that 76 per cent of Governments have enforced laws to guarantee women's property rights, including the right to own, buy and sell properties or other assets equally with men; this proportion increases to 86 per cent in Asia. While 65 per cent of Governments reported enforcing laws to guarantee equal rights for women to inherit, 72 per cent reported enforcing laws to protect women's property through harmonized laws on marriage, divorce, succession and inheritance. In both cases, the regional proportions were close to the world average, with the exception of Oceania, where the proportions fell to 50 per cent and 43 per cent respectively.

614. Despite these advances, many countries continue to have discriminatory property and inheritance laws or practices. Even where civil laws have been introduced to provide equal rights to inheritance and ownership, they are not necessarily implemented or respected at a local level owing to persistent discriminatory social norms and the application of customary or religious laws.

615. Analysis of data from the OECD Social Institutions and Gender Index shows that, for countries where data are available, women hold only 15 per cent of all land titles.[455] Where they are unable to exercise their rights to land, women are particularly at risk of eviction following the death of their husbands. Furthermore, as access to formal credit relies heavily on asset-based lending, land-poor borrowers are at a disadvantage; data confirm that women's reduced access to land limits their access to credit, thereby limiting women's economic opportunities.[456]

616. Moreover, women's poverty, coupled with a lack of alternative housing options, makes it difficult for women to leave violent family situations. Forced relocation and forced eviction from home and land have a disproportionately severe impact on women. Lack of property rights often prevent return following displacement, or may push women to stay with land even in the face of significant dangers. The impact of gender-based discrimination and violence against women on women's equal ownership of, access to and control over land and the equal right to

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[453] Food and Agriculture Organization of the United Nations (FAO), *Gender, Property Rights and Livelihoods in the Era of AIDS; FAO Technical Consultation, Rome 28-30 November 2007 — Proceedings Report* (Rome, 2008); available from ftp://ftp.fao.org/docrep/fao/010/ai521e/ai521e00.pdf.

[454] C. S. Rabenhorst and A. Bean, "Gender and property rights: a critical issue in urban economic development" (Washington, D.C., International Housing Coalition and Urban Institute, 2011).

[455] OECD, *2012 SIGI: Social Institutions and Gender Index: Understanding the Drivers of Gender Inequality*.

[456] N. Almodóvar-Reteguis, K. Kushnir and T. Meilland, "Mapping the legal gender gap in using property and building credit", Women, Business and the Law (World Bank, 2012).

own property and to adequate housing is acute, particularly during complex emergency situations, reconstruction and rehabilitation.[457]

617. **States should reform laws and address customs and traditions that discriminate against women and deny women security of tenure and equal ownership of, access to and control over land and equal rights to own property and to adequate housing. States should ensure the right of women to equal treatment in land and agrarian reform as well as in land resettlement schemes and in ownership of property, including through the right to inheritance, and should undertake administrative reforms and other necessary measures to give women the same access as men to credit, capital, markets and information.**

Human rights elaborations since the International Conference on Population and Development

Box 23
Women's access to land

Intergovernmental human rights outcomes. The Commission on Human Rights adopted a series of resolutions on women, housing, and land, including resolution 2005/25 on women's equal ownership, access to and control over land and the equal rights to own property and to adequate housing (2005), in which the Commission reaffirmed "women's right to an adequate standard of living, including adequate housing, as enshrined in the Universal Declaration of Human Rights and the International Covenant on Economic, Social and Cultural Rights", and affirmed "that discrimination in law and practice against women with respect to having access to, acquiring and securing land, property and housing, as well as financing for land, property and housing, constitutes a violation of women's human right to protection against discrimination and may affect the realization of other human rights".

2. Homelessness

618. An unknown but large number of people worldwide are homeless, that is, sleeping on the streets, in abandoned buildings, in makeshift structures, in parks or, where available, in shelters for the homeless.[458]

619. Homelessness is often considered an urban issue, but it impacts people in rural areas as well. At the time of the International Conference on Population and Development, estimates of rural homelessness in one country were between 7 and 15 per cent, and upwards of 20 per cent in river-eroded areas.[459] Natural disasters and internal displacement continue to cause rural homelessness in developing

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[457] See report of the Special Rapporteur on violence against women, its causes and consequences (E/CN.4/2000/68/Add.5).

[458] M. G. Haber and P. A. Toro, "Homelessness among families, children and adolescents: an ecological-development perspective", *Clinical Child and Family Psychology Review*, vol. 7, No. 3 (2004); P. A. Toro, "Towards an international understanding of homelessness", *Journal of Social Issues*, vol. 63, No. 3 (2007), pp. 461-481.

[459] T. Rahman, *The Rural Homeless in Bangladesh* (Dhaka, United Nations Children's Fund, 1993).

countries.[460] Homelessness is not only a problem of the poor in poor countries; a wide range of factors, including lack of social protection systems, limited public housing, income screening and vulnerable unemployment, combine to create homelessness in developed societies.[461]

620. The size of the homeless population worldwide is extremely difficult to determine because many countries lack any system for counting them. Homeless people, especially youth and families, cycle in and out of housing, and defining homelessness is complex. There are many persons who are precariously or inadequately housed or at imminent risk of becoming homeless, but they are not routinely included in estimates of the homeless. Determining estimates of the number of homeless persons is most difficult in the poorest societies and there is limited research from developing countries, despite growing recognition of the reality of highly vulnerable homeless populations, including street children.[462]

621. The homeless population is gaining growing attention in Europe (especially France, Germany, the United Kingdom and the Czech Republic), the United States, Japan and Australia. Findings in these countries identify common features among the homeless population, such as more men than women among the adult homeless; high rates of substance use and depression; and an overrepresentation of population groups that have traditionally experienced discrimination (e.g., African Americans in the United States; Aborigines in Australia; and recent immigrants from Africa, Asia, South America, the Middle East and Eastern Europe in Western Europe).[463]

622. When defining homelessness, it is important to distinguish between homeless single adults, homeless families and homeless youth, as these subgroups are often distinct in many dimensions.[464] Homeless families include intact (and even extended) families displaced by conflict or environmental crisis; when homelessness is due to extreme poverty or eviction, such families are more likely to include a single young mother with young children, who may also be escaping domestic

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[460] United Kingdom, University of Newcastle upon Tyne, Centre for Architectural Research and Development Overseas (CARDO), "The nature and extent of homelessness in developing countries", DFID Project No. 7905; available from http://r4d.dfid.gov.uk/PDF/Outputs/HumanSecurity/R7905.pdf.

[461] See for example European Federation of National Organisations Working with the Homeless, *European Report: The Role of Housing in Pathways Into and Out of Homelessness — Annual Theme 2008: Housing and Homelessness*; available from www.feantsa.org/spip.php?article156&lang=en.

[462] CARDO, "The nature and extent of homelessness in developing countries"; R. Carr-Hill, "Missing millions and measuring development progress", *World Development*, vol. 46 (2013), pp. 30-44; UNICEF, *The State of the World's Children 2006: Excluded and Invisible* (New York, 2005); T. Peressini, L. McDonald and D. J. Hulchanski, "Towards a strategy for counting the homeless", in *Finding Home: Policy Options for Addressing Homelessness in Canada*, D. J. Hulchanski and others, eds. (Toronto, University of Toronto, Cities Centre, 2009); G. Tipple and S. Speak, *The Hidden Millions: Homelessness in Developing Countries* (Abingdon, Oxon, Routledge, 2009).

[463] Toro, "Towards an international understanding of homelessness"; European Federation of National Organisations Working with the Homeless, "Immigration and homelessness in the European Union: analysis and overview of the impact of immigration on homeless services in the European Union" (2002); Australia, Australian Institute of Health and Welfare, *A Profile of Homelessness for Aboriginal and Torres Strait Islander People* (Canberra, 2001); *European Journal of Homelessness*, vol. 4 (December 2010).

[464] Haber and Toro, "Homelessness among families, children and adolescents: an ecological-development perspective".

violence.[465] Homelessness among families is on the rise in the European Union and in countries near areas coping with conflict or extreme poverty.[466]

623. Homeless youth differ from homeless adults because of their age (typically under 21), and from homeless children (in families) because they are homeless on their own. A variety of terms have been used to describe homeless youth, including runaways, throwaways and street youth, who may have raised themselves on the streets. These are not mutually exclusive groups. Most research has found roughly equal numbers of girls and boys among homeless adolescents, while boys are more common among older street youth.[467]

624. Homeless single adults are more likely to be male and between the ages of 18 and 50, with persons over 60 quite rare (less than 5 per cent; note that some homeless people look much older than their years, and there is some evidence that the homeless population is older now than it was a decade ago).[468] In countries where some, albeit incomplete, social data are available, adult homelessness has recognized social determinants, including a disproportionate number of persons who grew up as orphans, in foster care or unstable childhood housing; had a childhood or recent exposure to violence or a history of substance use; suffered racial or ethnic discrimination; are veterans of war; and are suffering from emotional and mental health disabilities, or other disabilities that preclude employment.[469]

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[465] Ibid.; M. Shinn and B. Weitzman, "Homeless families are different", in *Homelessness in America*, J. Baumohl, ed. (Phoenix, Arizona, Oryx Press, 1996); A. Masten and others, "Children in homeless families: risks to mental health and development", *Journal of Consulting and Clinical Psychology*, vol. 61, No. 2 (1993), pp. 335-343; D. J. Rog and J. C. Buckner, "Homeless families and children", paper prepared for the 2007 National Symposium on Homelessness Research, available from www.huduser.org/publications/pdf/p5.pdf; J. C. Buckner and others, "Homelessness and its relation to the mental health and behavior of low-income school-age children", *Developmental Psychology*, vol. 35, No. 1 (1999), pp. 246-257.

[466] European Federation of National Organisations Working with the Homeless, "Changing faces: homelessness among children, families and young people" (2010), and "Immigration and homelessness in the European Union: analysis and overview of the impact of immigration on homeless services in the European Union" (2002).

[467] Haber and Toro, "Homelessness among families, children and adolescents: an ecological-development perspective"; P. A. Toro, A. Dworsky and P. J. Fowler, "Homeless youth in the United States: recent research findings and intervention approaches", paper prepared for the 2007 National Symposium on Homelessness Research, available from http://aspe.hhs.gov/hsp/homelessness/symposium07/toro/; M. J. Robertson and P. A. Toro, "Homeless youth: research, intervention, and policy", in *Practical Lessons: The 1998 National Symposium on Homelessness Research*, L. B. Fosburg and D. L. Dennis, eds. (Washington, D.C., Department of Housing and Urban Development and Department of Health and Human Services, 1999); B. Feitel and others, "Psychosocial background and behavioral and emotional disorders of homeless and runaway youth", *Hospital and Community Psychiatry*, vol. 43, No. 2 (1992), pp. 155-159; M. J. Robertson, P. Koegel and L. Ferguson, "Alcohol use and abuse among homeless adolescents in Hollywood", *Contemporary Drug Problems*, Fall 1989, pp. 415-452.

[468] T. Meschede, B. Sokol and J. Raymond, "Hard numbers, hard times: homeless individuals in Massachusetts emergency shelters, 1999-2003" (Boston, Center for Social Policy, 2004); available from http://scholarworks.umb.edu/csp_pubs/29/.

[469] C. L. Caton, C. Wilkins and J. Anderson, "People who experience long-term homelessness: characteristics and interventions", paper prepared for the 2007 National Symposium on Homelessness Research; available from http://aspe.hhs.gov/hsp/homelessness/symposium07/caton/index.htm.

625. **States are called upon to promote new research on the demography and vulnerability of homeless populations and to design programmes to address the determinants of homelessness and to increase security of housing for all people.**

3. Forced evictions

626. Forced eviction involves State action, direct or indirect, to remove people from their land or homes involuntarily; it does not apply to evictions carried out both in accordance with the law and in conformity with the provisions of international human rights treaties.[470] Forced evictions eliminate the possibility of return for those who have been removed and are defined as such, regardless of whether assistance has been provided in resettlement to other areas.[471]

627. Causes of forced evictions commonly include urban development, large-scale development (such as dams) in rural areas, the threat of natural disasters and climate change, mega-events (for example, the Olympics or the World Cup), economic evictions and the global financial crisis, and discrimination or targeted punishment.[472]

628. Various efforts have been made to establish monitoring systems for forced evictions but the data are very limited, given the interest of its practitioners in hiding its occurrence. As such, estimates vary widely. In 1994, the World Bank estimated that about 10 million people per year were evicted due to public sector projects alone. Currently, estimates across the six key drivers of forced evictions range from about 2.5 million per year based on reported cases to upwards of 15 million per year.[473]

629. The United Nations Human Settlements Programme (UN-Habitat) is developing approaches to measuring tenure security, which it defines as a combination of "the degree of confidence that land users will not be arbitrarily deprived of the rights they enjoy over land and the economic benefits that flow from it; the certainty that an individual's rights to land will be recognized by others and protected in cases of specific challenges; or, more specifically, the right of all individuals and groups to effective government protection against forced evictions".[474] **States should end forced evictions that violate national and human rights law and establish mechanisms to monitor their occurrence and impact on affected populations.**

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[470] Basic principles and guidelines on development-based evictions and displacement, developed at an International Workshop on Forced Evictions, held in Berlin in June 2005 and co-organized by the Special Rapporteur on adequate housing as a component of the right to an adequate standard of living (A/HRC/4/18, annex I).

[471] Office of the United Nations High Commissioner for Human Rights (OHCHR), "Forced evictions and human rights", Factsheet No. 25 (May 1996).

[472] UN-Habitat, *Forced Evictions: Global Challenges, Global Solutions* (2011).

[473] M. M. Cernea and H. M. Mathur, eds., *Can Compensation Prevent Impoverishment? Reforming Resettlement through Investments and Benefit-Sharing* (New Delhi, Oxford University Press, 2008); and Centre on Housing Rights and Evictions, "Global survey 11: forced evictions, violations of human rights: 2007-2008" (Geneva, 2009).

[474] UN-Habitat, *Secure Land Rights for All* (Nairobi, 2008).

Human rights elaborations since the International Conference on Population and Development

Box 24
Forced evictions

Intergovernmental human rights outcomes. The Commission on Human Rights addressed forced eviction as a gross violation of human rights through a series of resolutions, including resolution 2004/28 on prohibition of forced evictions (2004), in which the Commission reaffirmed that "the practice of forced eviction that is contrary to laws that are in conformity with international human rights standards constitutes a gross violation of a broad range of human rights, in particular the right to adequate housing".

Other soft law. The Committee on Economic, Social and Cultural Rights addressed forced evictions in general comment No. 7 on the right to adequate housing: forced evictions (1997). The basic principles and guidelines on development-based evictions and displacement (2007), developed by the Special Rapporteur on the right to adequate housing as a component of the right to an adequate standard of living, "address the human rights implications of development-linked evictions and related displacement in urban and/or rural areas" (A/HRC/4/18, annex I, para. 3).

4. Internally displaced persons

630. Internal displacement implies a double vulnerability, to both the cause of displacement and to the tenuousness of well-being and security at points of destination. There are two main causes of internal displacement: armed conflict, generalized violence or human rights violations; and natural disasters.

631. Accurate statistics on internally displaced persons are particularly hard to obtain, since they often live in urban and other local communities, not refugee camps, or are dispersed geographically, making underestimations of their number very likely. At the same time, it is difficult to update statistics to reflect that some internally displaced persons may have returned home, which may lead to overestimation in some instances. Furthermore, data are seldom disaggregated: only 11 countries collect data on internally displaced persons disaggregated by sex, age and location.[475]

632. Worldwide, by the end of 2012, 28.8 million people had been internally displaced due to armed conflict, generalized violence or human rights violations.[476] At the time of the International Conference on Population and Development, there was a peak in the global number of persons displaced by war or conflict (see figure 50). Following a decline through the late 1990s, there was a steady increase in the number of internally displaced persons due to conflict, with recent estimates

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[475] Internal Displacement Monitoring Centre and Norwegian Refugee Council, *Global Overview 2012: People Internally Displaced by Conflict and Violence* (Geneva, 2013).

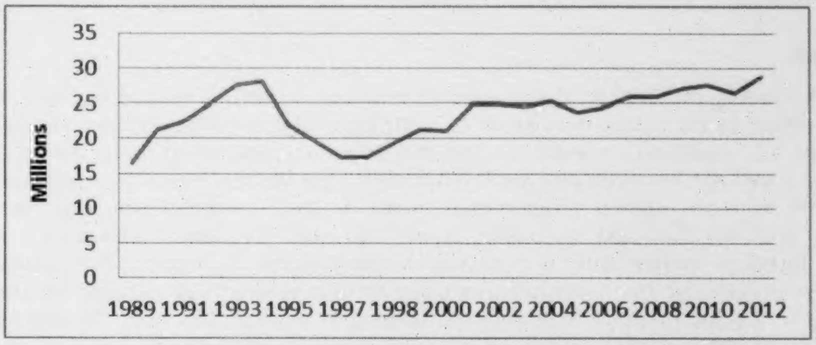
[476] Internal Displacement Monitoring Centre and Norwegian Refugee Council, *Global Estimates 2012: People Displaced by Disasters* (Geneva, 2013).

for 2013 surpassing the previously noted record numbers for 1994. In contrast to refugees, conflict-driven internally displaced persons do not cross international borders and therefore remain under their Governments' protection, even when those Governments have caused the displacement. The largest number of internally displaced persons, 10.4 million (an increase from 9.7 million in 2011), was in sub-Saharan Africa.[476] During 2012, about 2.1 million internally displaced persons reportedly returned to their areas of origin, including in Libya and the Democratic Republic of the Congo. In the Democratic Republic of the Congo, 450,000 people were reported to have returned to their places of origin, but monitoring systems are so limited that accuracy is impossible to determine.

Figure 50

Persons displaced internally owing to armed conflict, violence or human rights violations, 1989-2011

(Millions)



Source: Internal Displacement Monitoring Centre, Global Internally Displaced Persons Estimates (1990-2011), available from www.internal-displacement.org/8025708F004CE90B/(httpPages)/10C43F54DA2C34A7C12573A1004EF9FF?OpenDocument.

633. The International Displacement Monitoring Centre Global Estimates report estimates that 32.4 million people were forced to flee their homes in 2012 due to natural disasters such as floods, storms and earthquakes. For that year, nearly all of the displacement related to natural disasters was associated with climate and weather events. Floods in India and Nigeria, displacing 6.9 million and 6.1 million people respectively, accounted for 41 per cent of the global total.[476]

634. In the more developed countries, an additional 1.3 million were displaced, especially within the United States. Tracking displacement over time needs to be done carefully, as displacement caused by natural disasters depends in part on whether disasters occur in any given year; year-to-year variations are likely to be caused by fluctuations in the occurrence of natural hazards rather than to a particular trend of displacement. Nonetheless, social factors matter just as much as the occurrence of the hazard itself: whether as a result of the earthquake in Haiti (2010) or Hurricane Katrina in the United States (2005), the poor, marginalized and disadvantaged are the least well equipped to manage the consequences of displacement. In addition, climate change is projected to change the frequency,

intensity, spatial extent, duration and timing of extreme weather and climate events,[477] possibly increasing displacement in the near future.

635. People displaced by either conflict or natural disasters share significant vulnerabilities. Secondary displacement is common, that is, persons who are currently internally displaced may have been forcibly evicted because of discrimination or precarious housing situations. In 2011, this was the case in 18 of the countries monitored by the Internal Displacement Monitoring Centre. Unemployment is also generally higher among internally displaced persons.[478] By virtue of their displacement, internally displaced persons often lack documentation and authorization to work. All too often, internally displaced women have fewer options for income generation and, along with their children, turn overwhelmingly to precarious, low-paid, informal work and other strategies.[479] While females and males are generally displaced in equal numbers, social ruptures, temporary housing, scarcity of resources and lack of security can make conditions particularly unsafe for displaced women and girls, resulting in gender-based violence.[480]

5. Refugees

636. According to UNHCR, the number of refugees worldwide peaked in 1992 at 17.8 million. In 2012 there were about 15.4 million refugees, the largest group being Afghans (2.7 million) in Pakistan and the Islamic Republic of Iran, the two countries hosting the largest refugee populations within their borders. The four other countries with the highest refugee populations in 2012 were Somalia, Iraq, the Syrian Arab Republic and the Sudan. Jordan has been particularly affected by a recent influx of Syrians, after also having absorbed waves of Iraqi and Palestinian refugees previously. The overwhelming majority of global refugee populations are located in the Arab region. In addition to looking at absolute numbers, the United Nations has devised assessments of refugee impact by considering refugees in relation to economic capacity. Using that measure, Pakistan, followed by Ethiopia and Kenya, was the country most affected by refugee influxes in 2012.[481]

637. Refugees experience many of the same vulnerabilities as internally displaced persons, including the double vulnerability of displacement and loss of livelihood and well-being at points of settlement. As refugees face persecution and lack protection from their own State, countries of destination represent a viable solution for the protection, promotion and guarantee of their human rights and dignity. **States**

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[477] "Summary for policy makers", in *Managing the Risks of Extreme Events and Disasters to Advance Climate Change Adaptation: Special Report of the Intergovernmental Panel on Climate Change*, C. B. Field and others, eds. (Cambridge, Cambridge University Press, 2012).

[478] Internal Displacement Monitoring Centre, "Employment rate of IDPs"; available from www.internal-displacement.org/idmc/website/countries.nsf/%28httpEnvelopes%29/C3D334B77955EA84C12579C70059E6CA?OpenDocument; and "Barriers to Employment of IDPs"; available from www.internal-displacement.org/idmc/website/countries.nsf/%28httpEnvelopes%29/7D4A873BE935B1BBC12577ED005DDE12?OpenDocument.

[479] A. Fielden, "Ignored displaced persons: the plight of IDPs in urban areas", New Issues in Refugee Research Paper No. 161 (Office of the United Nations High Commissioner for Refugees, July 2008), pp. 9 and 12, available from www.unhcr.org/487b4c6c2.pdf; UNHCR, "IDP Working Group: internally displaced persons in Iraq — update" (June 2008), pp. 1 and 17, available from www.unhcr.org/491956e32.pdf.

[480] Internal Displacement Monitoring Centre, "Gender-based violence"; available from www.internal-displacement.org/thematic/women.

[481] UNHCR, "Displacement, the new 21st century challenge" (see footnote 390 above).

should strengthen the protections and assistance to internally displaced persons and refugees, through the provision of food, shelter, health, education and social services in the short term, and facilitating their local integration, voluntary return or, in the case of refugees, resettlement in a third country in the long term.

Human rights elaborations since the International Conference on Population and Development

Box 25

Internally displaced persons and refugees

Binding instruments. In 2009, the African Union adopted the Convention for the Protection and Assistance of Internally Displaced Persons in Africa to "[e]stablish a legal framework for preventing internal displacement, and protecting and assisting internally displaced persons in Africa".

Intergovernmental human rights outcomes. The Human Rights Council has adopted annual resolutions on the human rights of internally displaced persons, including resolution 20/9 on human rights of internally displaced persons (2012) and resolutions on human rights and mass exodus, concerning both internally displaced persons and refugees. The General Assembly has also adopted resolutions on internally displaced persons and mass exodus.

Other soft law. The Guiding Principles on Internal Displacement (1998) provide the most comprehensive set of human rights protections afforded to internally displaced persons to date. The Principles address the needs of internally displaced persons, and identify rights relevant to protecting persons from forced displacement and assuring their protection and assistance during displacement, as well as during return or resettlement and reintegration. The Principles on housing and property restitution for refugees and displaced persons (the Pinheiro Principles) (2005) contain standards on housing, land and property restitution rights for refugees and displaced persons. Regionally, the General Assembly of OAS adopted resolution 2229 (2006) in which the Assembly called on States to address factors that cause internal displacement and to provide internally displaced persons with assistance in line with the Guiding Principles. Similarly, in recommendation Rec(2006)6 the Council of Europe Committee of Ministers recommended that the Guiding Principles and other relevant international instruments should apply to internally displaced persons.

E. Place and mobility: key areas for future action

1. Development efforts must recognize and account for the increasing diversity of households and living arrangements.

638. Marriage patterns and the ways that people organize themselves into households have gone through enormous changes in the last 20 years, including a notable rise in the proportion of people living alone, marrying late or not at all, a greater risk of divorce and children living with a single parent, resulting in more diverse types of households. These changes fundamentally alter how we achieve the objectives of ensuring adequate, secure housing, the well-being of households and children, family support, long-term care for the elderly, social protection more broadly, and sustainable consumption and energy use. Many societies and legal systems continue to be oriented towards traditional, male-headed family structures despite the underlying changes. Women around the world suffer from limitations on their rights to property, including land ownership, leading to disproportionate poverty in households led by women, as well as from being denied inheritance in many countries and/or left to rely on relatives in the case of widowhood or divorce.

2. The world must plan and build sustainable cities.

639. The world's urban population is currently growing by more than 1.3 million people each week. This unprecedented growth represents people's aspirations for better prospects and a critical opportunity for achieving sustainable development, if the right policies are put in place. The benefits of proximity, concentration and scale in urban areas make it easier and cheaper for the State to provide basic health, welfare and education, while at the same time maximizing energy and efficient use of resources. Cities provide major economic advantages for work and entrepreneurship, and similar advantages for social and political participation and empowerment. Yet the rise of urban inequality has increased marginalization in cities, including through the growth of urban slums, exacerbated urban sprawl and limited the ability of Governments to ensure the safety of urban residents. Urban management, including of traffic, service provision and housing, is increasingly stressed as cities grow, and the poorest residents are inevitably impacted most. The most significant challenge for urbanization is not to slow its occurrence — which has consistently proven unsuccessful — but to extend the full set of potential benefits of urban life to all current and future urban residents.

3. The international community should make migration work for development and ensure the rights and security of migrants.

640. The total estimated number of international migrants in the world has increased since 1990, but of greater impact has been the diversification of migration patterns, which means that a growing number of countries are affected. Migrants' formal remittances are significantly greater than official development assistance and a vital part of the development process. Today's migrants come from a broader spectrum of cultural, economic and social backgrounds than ever before, and approximately half are now women. While many are taking advantage of new opportunities, others, particularly women, are victims of trafficking, exploitation, discrimination and other abuses. The call for increased international, regional and bilateral cooperation made at the International Conference on Population and Development continues to be relevant, and requires accelerated efforts to protect, respect and fulfil the human rights and well-being of migrants, reduce the cost of migration, enhance the knowledge base on migrants and address attitudes and values

that stigmatize migrants and obstruct their contributions to their countries of origin, transit and destination.

4. Insecurity of place is a threat to dignity.

641. Far greater demographic and policy attention must be given to those without security of place, including those displaced by conflict or natural disasters, those in refugee circumstances, those living in areas of conflict, those in temporary or insecure housing, and the homeless. Insecurity of place is a threat to dignity, and leads to a disproportionate risk of violence, poverty, and adverse health outcomes. People without security of place are often uncounted and therefore not recognized by the State, heightening the overall precariousness of their living conditions, including the risks of exploitative and dangerous employment. Assessments of the number of those without security of place have been gradually improving, but far better monitoring and demographic attention are required to enable Governments to provide social protection, health services, security and, ultimately, full social integration.

V. Governance and accountability

"Governments ... should work to increase awareness of population and development issues and formulate, implement and evaluate national strategies, policies, plans, programmes and projects that address population and development issues, including migration, as integral parts of their sectoral, intersectoral and overall development planning and implementation process. They should also promote and work to ensure adequate human resources and institutions to coordinate and carry out the planning, implementation, monitoring and evaluation of population and development activities."

(Programme of Action, para. 13.5)

"Governments, civil society at the national level and the United Nations system should work towards enhancing and strengthening their collaboration and cooperation, with a view to fostering an enabling environment for partnerships for the implementation of the Programme of Action. Governments and civil society organizations should develop systems for greater transparency and information-sharing, so as to improve their accountability."

(Key actions for the further implementation of the Programme of Action of the International Conference on Population and Development, para. 78)

"Governments ... should strengthen their national capacity to carry out sustained and comprehensive programmes on collection, analysis, dissemination and utilization of population and development data."

(Programme of Action, para. 12.3)

642. The world has seen important shifts in the diffusion of authority and leadership since 1994, with growing recognition of the importance and power of a multiplicity of regional, national, local, civil society, private sector and other non-State actors. Understanding of governance has shifted from a dominant focus on the State to recognition of the critical importance of partnerships for governance, and of how significantly partnerships between stakeholders undergird progress towards, or away

from, the fundamental development aims of dignity, human rights, equality and sustainability.[482]

643. States have the responsibility of designing and implementing transparent laws, policies and programmes with clear goals, benchmarks and adequate budgetary allocations, as well as monitoring and evaluation systems. Monitoring and evaluation of the implementation of laws, policies and programmes need to be grounded in comprehensive, reliable, accessible, transparent and periodic information and data. Much of the existing data remain underutilized, especially in the developing world, and are not adequately brought to bear on development planning, budgeting or evaluation, calling for new investments in capacity-strengthening.

644. As a cornerstone of good governance, accountability requires national leadership, effective State institutions, and enabling laws, policies, institutions and procedures for the free, active, informed and meaningful participation of people, without discrimination. Accountability represents a shift from needs to rights, to which all individuals are entitled; such a shift has the potential to transform power relations, between men and women, service providers and users, and Governments and citizens. States are obligated to respect, protect and fulfil human rights. Furthermore, mechanisms need to be in place to provide redress and remedies when the rights of individuals are violated or at risk of being violated.

645. Momentum was generated by the International Conference on Population and Development for the creation and renewal of institutions to address population and sustainable development, the needs of adolescents and youth, and women's empowerment and gender equality. The past 20 years have seen a measurable increase in the formal participation of intended beneficiaries in the planning and evaluation of investments related to the International Conference, via recognition and integration of wide networks of civil society and non-governmental organizations.

646. Resources for development have undergone a seismic shift, influenced by the HIV crisis, donor commitments to the Millennium Development Goals, the economic crisis of 2008, and the emergence of new donor Governments as well as enormously influential individual donors and foundations. Resource flows for efforts related to the International Conference on Population and Development have been significantly impacted, and the agenda has been shaped by new sources of funds.

647. These changes — the growing integration of population dynamics in development planning, greater participation and cooperation in development policy, changing resource flows and growing global accountability systems for human rights and development — offer the potential for more evidence-based, transparent, accountable and effective governance beyond 2014.

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[482] Report of the Secretary-General entitled "A life of dignity for all: accelerating progress towards the Millennium Development Goals and advancing the United Nations development agenda beyond 2015" (A/68/202); report of the United Nations system task team on the post-2015 United Nations development agenda entitled "Realizing the future we want for all" (2012).

Human rights elaborations since the International Conference on Population and Development

Box 26

Good governance

Intergovernmental agreements. The Commission on Human Rights adopted a series of resolutions on the relationship between governance and human rights, including resolution 2005/68 on the role of good governance in the promotion and protection of human rights (2005), in which the Commission urged "States to provide transparent, responsible, accountable and participatory government, responsive to the needs and aspirations of the people, including members of vulnerable and marginalized groups, and to respect and protect the independence of judges and lawyers in order to achieve the full realization of human rights", and recognized "the need for Governments to ensure that services are delivered to all members of the public in a transparent and accountable manner that is adapted to the particular needs of the population and promotes and protects human rights".

Other soft law. In general comment No. 12 on the right to adequate food (1999), the Committee on Economic, Social and Cultural Rights stated, "Good governance is essential to the realization of all human rights, including the elimination of poverty and ensuring a satisfactory livelihood for all." General comment No. 10 (1998) highlights the role of national human rights institutions in the protection of economic, social and cultural rights. General comment No. 9 (1998), on the domestic application of the International Covenant, provides a more developed elaboration on the governance systems and accountability mechanisms required in ensuring the effective application of economic, social and cultural rights.

A. Establishment of government institutions related to the Programme of Action

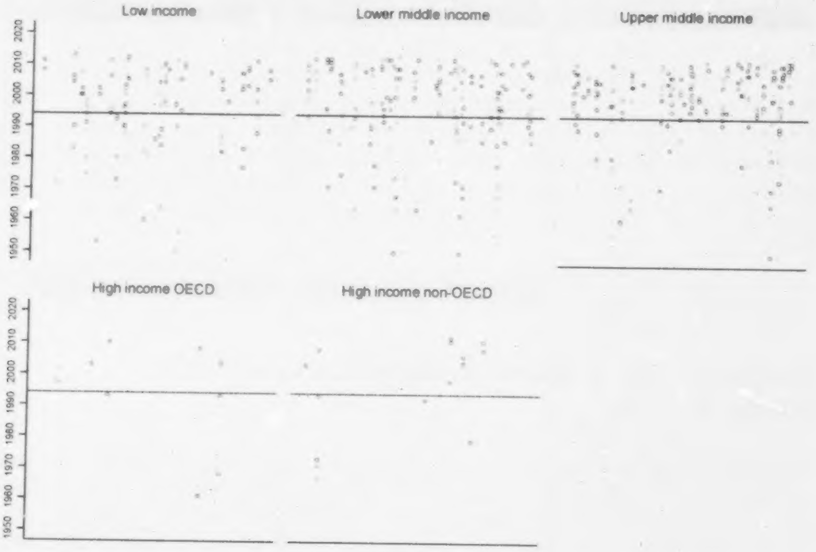
648. The Programme of Action of the International Conference on Population and Development called on Governments to ensure adequate institutions to carry out the planning, implementation, monitoring and evaluation of population and development activities. The global survey asked Governments whether they had "established any institutional entities to address issues related to the interaction between population and development". The Programme of Action mentioned 11 major policy areas: population dynamics and sustainable development; gender equality and women's empowerment; older persons; adolescents and youth; persons with disabilities; indigenous peoples; urbanization and internal migration; international migration; family; sexual and reproductive health and rights; and education.

649. Countries were asked to identify the year in which those institutions were established. The majority of Governments reported that a wide range of institutions had been established over the past 30-50 years, with some established as far back as the last century.

650. For 3 of the 11 topics — population dynamics and sustainable development; gender equality and women's empowerment; and adolescents and youth — institutional expansion in the 1990s was notable, suggesting that the International Conference on Population and Development and related conferences such as the United Nations Conference on Environment and Development (1992) and the Fourth World Conference on Women (1995) had generated an expansion or reconfiguration of development-related institutions in countries. Figures 51, 52 and 53 illustrate these trends. Countries have been grouped according to World Bank income classifications, and for each income group one hollow circle represents one institution. The height of the circle represents the year of the institution's establishment, and institutions in the same country are aligned vertically. The horizontal line marks 1994, recognizing that the International Conference on Population and Development was only one of several development-focused international conferences during the 1990s. The establishment or reconfiguration of institutions is to be taken at face value, as the data provide no indication of the budget, manpower or mandate of the institutions listed.

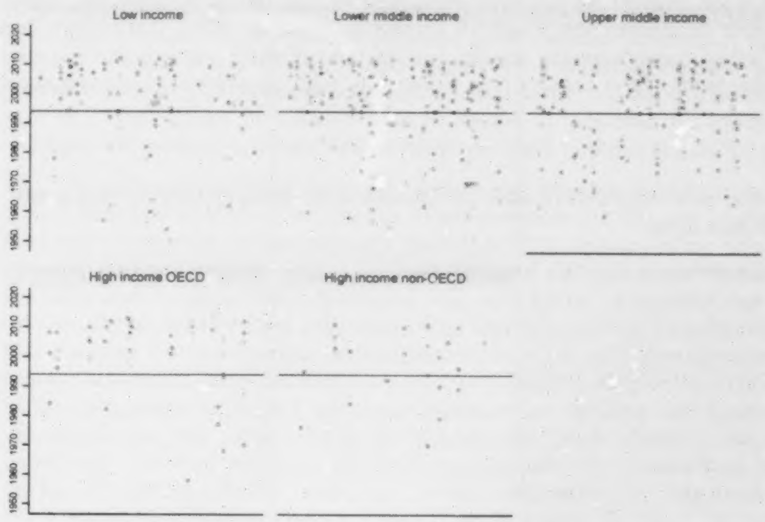
Figure 51

Establishment of institutions to address population, sustained economic growth and sustained development, by country income group and year of establishment



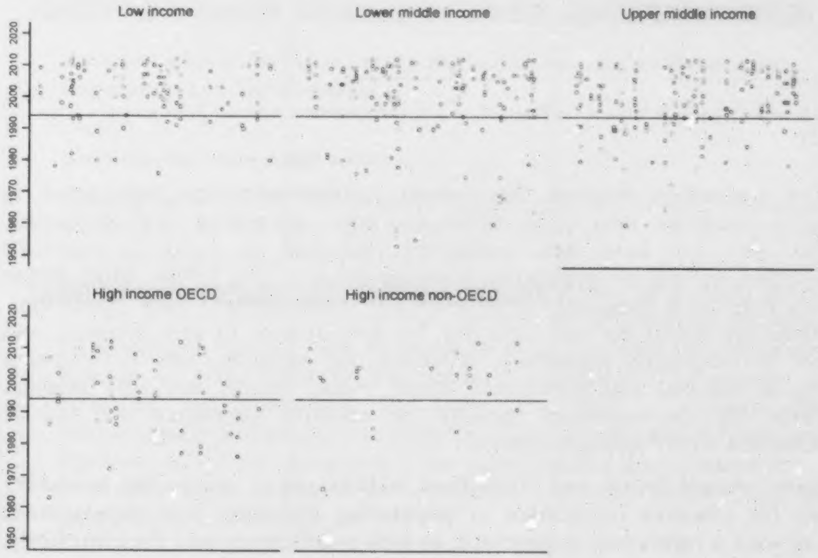
Source: International Conference on Population and Development beyond 2014 global survey (2012).

Figure 52
Establishment of institutions to address the needs of adolescents and youth, by country income group and year of establishment



Source: International Conference on Population and Development beyond 2014 global survey (2012).

Figure 53
Establishment of institutions to address gender equality and women's empowerment, by country income group and year of establishment

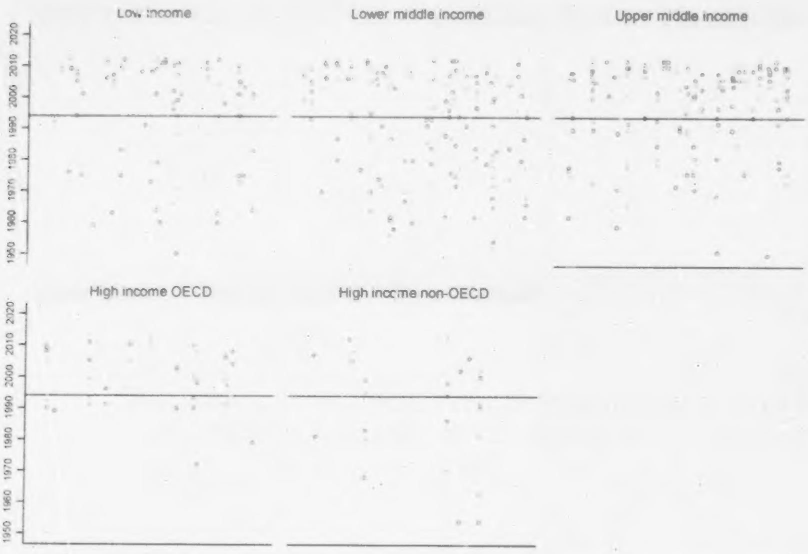


Source: International Conference on Population and Development beyond 2014 global survey (2012).

651. Overall, the evidence suggests greater relative growth in government institutions to address gender equality, adolescents and youth, and population and sustainable development since the 1990s; this clustering of newly established institutions is not evident for the other eight themes. The theme of education serves as an example of themes for which Governments reported many institutions that were established throughout the second half of the twentieth century and the first decade of the twenty-first century (see figure 54), with no explicit clustering since the 1990s.

Figure 54

Establishment of institutions to address education, by country income group and year of establishment



Source: International Conference on Population and Development beyond 2014 global survey (2012).

652. The scatterplots suggest that greater institutionalization took place in developing countries relative to richer countries, suggesting that developing countries may not have had institutions dedicated to youth or women's empowerment or use of population planning prior to the 1990s, while richer countries may have previously established (or mainstreamed) such institutions. Institutions are useful but not sufficient for development in new domains, and progress in integrating population dynamics, for example, into development planning at national and subnational levels would require not only relevant institutions, but the necessary capacity for effective generation and use of population data within multiple sectors.

653. **States should create and strengthen institutions to ensure the necessary capacity for effective integration of population dynamics into development planning with a rights-based approach, as well as efficiency and accountability, including ensuring effective coordination of all relevant social and planning bodies.**

B. Strengthening the knowledge sector related to the Programme of Action

654. Sustainable development cannot be achieved without evidence-based governance. Effective governance demands good statistics to monitor progress and to hold leaders accountable for their activities and achievements. Investing in statistical capacity in demography, public health, human rights, migration, economic growth, employment or climate change makes it possible to understand their linkages and impact on sustainable development, and to shape the policy process.

655. To address increasing inequality within countries, to better target vulnerable populations and to ensure the benefits of development for all, subnational and local data and projections are increasingly necessary. This responsibility falls largely on national statistical offices, which are responsible for a wide array of data including censuses and surveys, vital registration, and administrative systems that enable the monitoring of development indicators. The objective of the Programme of Action that focused on the integration of population data into development planning (para. 3.4) has not been realized in the last two decades, despite detailed elaboration in the Programme of Action and its importance for ensuring development without discrimination. No clear social movement has been pushing for this more technically oriented and systems-level agenda, and the momentum to establish academic centres, think tanks, or strong ministries or departments within Government has been sporadic at best. There is a need for stronger links between national statistical offices, academic researchers and ministries (health, planning, finance, environment and others). While national statistical offices have made significant advances in the collection of disaggregated population data during the past 20 years, many countries lack established channels for providing population data directly to line ministries based on specific needs, nor is there necessarily an avenue for their analysis, nor strong partnerships between university researchers and government leaders.

Human rights elaborations since the International Conference on Population and Development

Box 27
Building the knowledge sector

Binding instruments. International human rights instruments emphasize the importance of data collection and statistics for evidence-based programme planning. For example, article 31 of the Convention on the Rights of Persons with Disabilities (2006; entry into force 2008) states, "States Parties undertake to collect appropriate information, including statistical and research data, to enable them to formulate and implement policies to give effect to the present Convention. The process of collecting and maintaining this information shall … comply with internationally accepted norms to protect human rights and fundamental freedoms and ethical principles in the collection and use of statistics. … The information collected in accordance with this article shall be disaggregated, as appropriate. …"

Intergovernmental human rights outcomes. The Human Rights Council has adopted resolutions on freedom of expression, including freedom of information. In resolution 12/16 on freedom of opinion and expression (2009), the Council stressed the "importance of the full respect for the freedom to seek, receive and impart information, including the fundamental importance of access to information, democratic participation, accountability and combating corruption".

Other intergovernmental outcomes. Strategic objective H.3 of the Beijing Platform for Action (1995) called for the generation and dissemination of "gender-disaggregated data and information for planning and evaluation" and called upon the United Nations to "promote the development of methods to find better ways to collect, collate and analyse data that may relate to the human rights of women, including violence against women, for use by all relevant United Nations bodies".

Other soft law. The *Guiding Principles on Extreme Poverty and Human Rights* (2012) highlight that "States should ensure that the design and implementation of public policies, including budgetary and fiscal measures, take into account disaggregated data and up-to-date information".

1. Civil registration

656. Civil registration and the resulting vital statistics are key public goods that benefit individuals and enable good governance. Civil registration is the compulsory, permanent, continuous and universal recording of the occurrence and characteristics of vital events. Through the official recording of births, deaths, marriages, divorces and adoptions, it provides individuals with the documentary recognition of their legal identity, their family relationships, their nationality and their ensuing rights. In most countries these records are also a source of vital statistics, serving the planning and monitoring needs of almost all development sectors, including health.

657. Recognition of the importance of legal identity by the international development and human rights communities has led to the increased profile of birth registration as a human rights issue. While the most developed countries have achieved universal coverage, in the least developed countries only about one third of births are registered, despite an almost 30 per cent increase since 2000.[483] Birth registration[484] is the lowest in South Asia (39 per cent of births are registered) and sub-Saharan Africa (44 per cent), with birth registration rates of less than 10 per cent in Ethiopia, Liberia and Somalia.[483] In countries with incomplete birth registration, rural areas and the poorest households have the greatest disadvantage.[483] For example, the difference in birth registration between urban and

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[483] UNICEF, *Every Child's Birth Right: Inequities and Trends in Birth Registration* (New York, 2013), pp. 40-43.

[484] Birth registration is calculated as the percentage of children less than 5 years old who were registered at the moment of the survey. The numerator of this indicator includes children whose birth certificate was seen by the interviewer or whose mother or caretaker says the birth has been registered.

rural areas can be as high as over 40 percentage points in Guinea and the Niger, while the difference between the richest and poorest household wealth quintile can be as high as over 50 percentage points in Guinea, Mauritania, Nigeria, the Sudan and the United Republic of Tanzania.

658. The problems surrounding civil registration often disproportionately affect women. For example, women who have difficulty in registering the births of their children in the absence of a male relative are often unable to claim financial and social support for their children, as well as nationality. Research commissioned by Plan International identified discriminatory laws that prevent a woman from registering her child alone and/or from conferring her nationality to her son or daughter. The research also shows that discrimination occurs in practice, even when legislation is gender-neutral.[485] For example, in Brazil, the Dominican Republic, Ecuador, India, the Lao People's Democratic Republic, Nepal, Pakistan and the Sudan, the law states that if a birth takes place at home, the primary responsibility for the registration of a child lies with the head of the household. In most cases this will be the husband or, for single women, their father or another male relative; rarely will a woman be head of household herself, and therefore she may have difficulties in registering her own child.[485] Several studies have also identified the importance of civil registration in order to be able to access services in cases of conflict or disaster. Surviving women and children face particular challenges in proving their identity when identity is largely established through male family members.[486]

659. Civil registration systems characterized by universal coverage and continuity are a source of vital statistics unmatched by other data-gathering methods. However, with regard to the number of countries in the world that provide quality statistics based on universal civil registration, there has been very little improvement over the past 30 years.[487] Currently, of 193 States Members of the United Nations, only 109 (56 per cent) have complete coverage[488] (90 per cent or more) of birth registration and 99 (51 per cent) have complete coverage of death registration.[489] Europe stands out as the only region with complete registration of births and deaths. By contrast, in Africa, only 10 countries have complete coverage of births (19 per cent of 54 countries in the region) and 5 countries have complete coverage of deaths (9 per

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[485] R. M. M. Wallace and others, *Mother to Child: How Discrimination Prevents Women Registering the Birth of their Child* (Plan International and Perth College, UHI Centre for Rural Childhood, 2009).

[486] A. M. Azarian and M. Pelling, "Social resilience of post-earthquake Bam"; available from www.arber.com.tr/aesop2012.org/arkakapi/cache/absfilAbstractSubmissionFullContent1071.docx.

[487] P. W. Setel and others, "A scandal of invisibility: making everyone count by counting everyone", *The Lancet*, vol. 370, No. 9598 (2007), pp. 1569-1577; P. Mahapatra and others, "Civil registration systems and vital statistics: successes and missed opportunities", *The Lancet*, vol. 370, No. 9599 (2007), pp. 1653-1663.

[488] The assessment of coverage is based on self-reporting on quality and coverage of vital statistics obtained from civil registration of national statistical offices to the United Nations Statistics Division, supplemented by self-reporting during workshops on civil registration and vital statistics conducted by the Statistics Division. When self-reporting information is not available, additional sources are used, including the International Institute for Vital Registration and Statistics, the UNICEF Multiple Indicators Cluster Survey, the Demographic and Health Surveys programme of ICF International and/or the World Health Organization.

[489] Analysis based on data from the Statistics Division, 2012; see http://unstats.un.org/unsd/demographic/CRVS/CR_coverage.htm (downloaded December 2013).

cent). In the other regions, the proportion of countries with complete registration of births and deaths varies from less than half to less than two thirds.

660. Furthermore, quality data on causes of death based on civil registration systems are provided by an even smaller number of countries. For example, an analysis of data availability between 1996 and 2005[490] shows that only 13 per cent of countries were able to provide high-quality cause-of-death data (defined by 90-100 per cent completeness, use of a recent version of the WHO International Classification of Diseases, and less than 10 per cent ill-defined codes for cause of death). By comparison, 72 per cent of countries have not reported cause-of-death data to WHO, or the reported data were of low quality or limited use. The remaining 15 per cent of countries had cause-of-death data of medium quality.

661. In countries with inadequate civil registration systems, gaps in data on births, deaths and causes of death have been filled in the last 20 years by estimates or extrapolations from household surveys, population censuses and demographic surveillance sites. Such alternative data collection systems have been viewed as reasonable interim substitutes for civil registration, with the exception of the assessment of causes of death. They are not, however, a long-term alternative to the development of complete national civil registration systems that are able to provide, on a current and continuous basis, data at the most disaggregated level for government functioning.[491]

2. Population censuses

662. Population census is the primary source of information on the size, distribution and characteristics of a country's population and the basis for calculation, estimation and projection of a variety of indicators needed for policymaking, planning and administration in all development sectors. Censuses have the potential to provide data at the lowest geographical levels and in countries with incomplete civil registration systems, population censuses, along with household surveys, provide needed statistics on vital events.[492]

663. Population censuses cover a variety of topics. In the 2010 census round, data on basic demographic characteristics of age, sex, marital status, labour force participation and occupation were collected in all or nearly all countries implementing a population census.[493] Migration was also covered by the majority of countries, with a higher proportion of countries inquiring about international, compared to internal, migration. Education characteristics ranked high in coverage, with data on school attendance and educational attainment collected by a majority of countries in all regions, and literacy by a majority of countries in Africa, South

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[490] Mahapatra and others, "Civil registration systems and vital statistics: successes and missed opportunities".

[491] See for example, K. Hill and others, "Interim measures for meeting needs for health sector data: births, deaths, and causes of death", *The Lancet*, vol. 370, No. 9600, pp. 1726-1735; United Nations, Statistics Division, *Principles and Recommendations for a Vital Statistics System: Revision 3* (forthcoming).

[492] *Principles and Recommendations for Population and Housing Censuses: Revision 2*, Statistical Papers, Series M, No. 67/Rev.2 (United Nations publication, Sales No. E.07.XVII.8).

[493] Assessment based on analysis of 124 census questionnaires (most covering countries with traditional censuses) conducted by the Statistics Division, as shown in "Implementation of United Nations recommendations for population census topics in the 2010 round" (ESA/STAT/AC.277/4).

America and Asia. With the exception of Europe, data on disability status was collected by a majority of countries in all regions.[493]

664. Census coverage of fertility and mortality was lowest in Europe and highest in Africa, reflecting the regional differences in availability of vital statistics from civil registration. For example, data on household deaths in the previous 12 months, a topic related to maternal mortality, were covered better in Africa (74 per cent of countries) and Asia (48 per cent) and not covered at all in Europe.[493] Although some countries had already included questions on maternal mortality in their 2000 censuses, the number of countries that did so grew considerably in the 2010 census round.

665. For the 2010 World Census Programme, the Statistics Division reported that only 7 of the 193 States Members of the United Nations either would not conduct a census, or no information was available with regard to their census plans (as at 1 December 2013), compared with 25 countries in the 2000 census round. According to a survey carried out by the Statistics Division (June 2013),[494] there has been increased use of alternative census methodologies and technological advances to reduce costs and improve the quality and timeliness of data. In terms of advanced technologies, the geographic information system (GIS) was the most widely used, of great benefit to cartography. The fast-growing capabilities of GIS and easier access to imagery, and Global Positioning System (GPS) coordinates, have considerably improved the quality of the maps produced for census purposes. The survey results show that 75 countries (64 per cent) used GIS in their 2010 census round. This is the most used type of technology, especially in Africa, North America and Asia. Use of technologies to enable faster release of census data has also been increasing, including computer-assisted coding (49 per cent of countries), the Internet (43 per cent), optical character recognition (42 per cent), optical mark recognition (33 per cent) and other imaging and scanning methods (38 per cent).[495]

666. Dissemination was the weakest point of the censuses of the 2000 round, with important implications for public policy and the integrated use of population dynamics in development planning. Census data have been disseminated by a wider variety of media, including CD-ROM/DVD, static web pages, online databases and GIS web-based mapping tools, yet many developing countries could not fully disseminate their census results to the public. The main method for the dissemination of census results continues to be paper publications (52 per cent of countries), followed by static web pages (28 per cent) and interactive databases (14 per cent). In the African region paper publications are the method used by the majority of countries (89 per cent), followed by static web pages (8 per cent). In Europe this is inverted, with static web pages (39 per cent) and interactive databases (36 per cent) the top two, followed by paper publications (22 per cent). South America has the highest percentage of countries using interactive databases (43 per cent) for census data dissemination, followed by static web pages (29 per cent) and paper publications and CD-ROMs/DVDs (both 14 per cent).[495]

667. Concerns have been raised that there are a declining number of census experts and demographers available to national statistical offices in developing countries to conduct and analyse their censuses, concerns that warrant further analysis.

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[494] "Mid-decade assessment of the United Nations 2010 World Population and Housing Census Programme", prepared by the United States Bureau of Census (ESA/STAT/AC.277/1).

[495] Statistics Division, "Overview of national experiences for population and housing censuses of the 2010 round" (2013); and 2010 World Population and Housing Census Programme, available from http://unstats.un.org/unsd/demographic/sources/census/2010_PHC/default.htm.

668. States should strengthen national capacity to generate, disseminate and effectively use data on population dynamics, including data from birth and death registration, censuses and periodic representative surveys. Attention should be given to the need for training and career development of young demographers in developing countries, especially training in the newer technologies.

669. States and international institutions should strengthen efforts to improve data availability, quality and accessibility and place more population, health and development data in the public domain in order to facilitate sharing and use of knowledge.

3. Surveys

670. Household surveys focusing on demographic and health data have been a valuable resource for the development field since the 1970s, providing critical population data for countries lacking reliable vital registration.

671. The demographic and household surveys, initially begun as the World Fertility Survey, were already one of the world's most valuable sources of nationally comparative data on fertility and maternal and child health by the 1980s. They were subsequently expanded to collect new data on sexual, reproductive and gender outcomes throughout the 1990s, including female genital mutilation/cutting, HIV behaviour and HIV knowledge, among others, and to include youth, men and unmarried women, and even health biomarkers, in selected countries. Likewise, the multiple indicator cluster surveys provide internationally comparable data on the situation of children and women, with demographic and household surveys and multiple indicator cluster surveys providing complementary coverage in many developing countries, although they were not fully comparable in their implementation.

672. Despite the recent expansion of these household surveys on many health and population topics, other gaps remain, for example on the health of younger adolescents (10-14 years), older persons, migration behaviour and household behaviour relevant to environmental sustainability, among others. Likewise, while the data enable broad stratification across states within countries, and attention to rural-urban differences, further spatial disaggregation into extreme rural, periurban, and small, medium or megacities, for example, is generally not possible.

673. Critical to goals of building accessible public knowledge, both demographic and household surveys and multiple indicator cluster surveys provide free access to their data, including compiler programmes, to facilitate easy public use of the data. There are critical uncertainties in the representativeness of household surveys, as sampling frameworks are based on the most recent census, which may be out of date. Nevertheless, these household surveys continue to be enormously helpful in generating estimates of key population, health and demographic data over time in countries where otherwise little to no such data are available.

Improvements in sexual and reproductive health data

One of the singular challenges after the International Conference on Population and Development was how to improve sexual and reproductive health without reliable data on sexual and reproductive health epidemiology, especially in developing countries. While the Programme of Action broadly defined an essential package of sexual and reproductive health services, many countries lacked the necessary data on absolute or relative needs in their own countries that would enable them to set priorities and target the problems causing the most severe burden of sexual or reproductive ill-health. Indeed, reliable data were least available where the burden of illness was assumed to be highest.

Studies from rural India[496] and Egypt[497] in the early 1990s had suggested a high prevalence of unreported reproductive and sexual morbidities in poor communities, but there was no ongoing surveillance of reproductive or sexual morbidity at the population level in 1994, beyond the important estimates of maternal mortality emanating from civil registration, demographic and household surveys and reproductive-age mortality studies. The lack of reproductive morbidity data from Africa in the 1990s was especially striking, given that small studies suggested that the continent had among the highest rates of both maternal morbidity and mortality worldwide, and it was well known that women had limited access to health care.[498]

One of the greatest achievements since the International Conference has been the improvement in the scope and quality of the available epidemiological and behavioural data on sexual and reproductive health from the developing countries, including the expansion and refinement of outcome measures in demographic and household surveys, multiple indicator cluster surveys and national family health surveys, the growth of demographic surveillance sites and substantial new surveillance efforts undertaken to monitor HIV- and AIDS-related burdens, including the increase in sexual behaviour research prompted by efforts to intervene and reduce sexual transmission.[499] Much of the latter has not been systematic on a global scale.

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[496] R. A. Bang and others, "High prevalence of gynecologicial diseases in rural Indian women", *The Lancet*, vol. 333, No. 8629 (1989), pp. 85-88.

[497] H. Zurayk and others, "Comparing women's reports with medical diagnoses of reproductive morbidity conditions in rural Egypt", *Studies in Family Planning*, vol. 26, No. 1 (1995), pp. 14-21; N. Younis and others, "A community study of gynecological and related morbidities in rural Egypt", *Studies in Family Planning*, vol. 24, No. 3 (1993), pp. 175-186.

[498] T. Boerma, "The magnitude of the maternal mortality problem in sub-Saharan Africa", *Social Science and Medicine*, vol. 24, No. 6 (1987), pp. 551-558; J. C. Anosike and others, "Trichomoniasis amongst students of a higher institution in Nigeria", *Applied Parasitology*, vol. 34, No. 1 (1993), pp. 19-25; K. Harrison, "Childbearing, health and social priorities: a survey of 22,774 consecutive hospital births in Zaria, northern Nigeria", *British Journal of Obstetrics and Gynaecology*, vol. 92, Suppl. 5 (1985), pp. 1-119; W. A. Cronin, M. G. Quansah and E. Larson, "Obstetric infection control in a developing country", *Journal of Obstetric, Gynecologic, and Neonatal Nursing*, vol. 22, No. 2 (1993), pp. 137-144; P. Bimal Kanti, "Maternal mortality in Africa: 1980-87", *Social Science and Medicine*, vol. 37, No. 6 (1993), pp. 745-752; P. Thonneau and others, "Risk factors for maternal mortality: results of a case-control study conducted in Conakry (Guinea)", *International Journal of Gynecology and Obstetrics*, vol. 39, No. 2 (1992), pp. 87-92.

Gaps remain in both scope and quality, particularly for stigmatized events and outcomes such as abortion, interpersonal violence, sexually transmitted infections, obstetric fistula, morbidities such as incontinence, pain with intercourse and sexual dysfunction, among others. The lack of adequate global surveillance for sexually transmitted diseases is especially egregious given evidence that incident cases of sexually transmitted infections appear to have increased since 1994. In addition, as urbanization progresses, the conventional stratification of rural or urban may no longer offer adequate analytical insight to health differentials, requiring more spatial typologies including megacities, small and medium cities and remote rural areas, among others.

674. While demographic and household survey and multiple indicator cluster surveys offer core population health data for the widest number of developing countries, other multinational household surveys, for example the World Bank's Living Standards Measurement Study surveys, have generated nationally representative data on complementary topics such as household income, expenditures and well-being, allowing comparative analysis between countries.

675. Monitoring of select sexual and reproductive health-related outcomes was made universal since 2000 — or 2005 after they were included among indicators for tracking progress towards the Millennium Development Goals — but the choice of corresponding indicators has received a mixed response, at best, from evaluation experts.

676. Public opinion surveys offer a potentially powerful instrument for monitoring public attitudes to many key dimensions of development, such as attitudes towards gender or racial equality, trust in the State or religious authorities and belief in public participation and democracy. Many private public opinion polls demand high fees to collect such data. The World Values Survey conducts representative national surveys on peoples' values and beliefs regarding many population groups and values pertinent to human rights. For example, the latest round of surveys includes a module on attitudes towards older persons and their value to society. The World Values Survey has been conducted in almost 100 countries, and includes repeating surveys in some countries. The findings on attitude surveys are especially valuable for policymakers seeking to identify where stigma and discrimination may be most entrenched, and therefore where individuals may be vulnerable.

677. **States should integrate into the national statistics the measurement of public values and attitudes regarding gender inequality, ageism, racism and other forms of discrimination. Such data can elaborate conditions and localities of extreme stigma, enabling social protection and efforts to redress discrimination.**

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[499] M. Hunter, "Cultural politics of masculinities: multiple partners in historical perspective in KwaZulu-Natal", in *Men Behaving Differently: South African Men since 1994*, G. Reid and L. Walker, eds. (Cape Town: Double Storey Books, 2005), pp. 139-160; I. A. Doherty and others, "Determinants and consequences of sexual networks as they affect the spread of sexually transmitted infections", *Journal of Infectious Diseases*, vol. 191, No. 1 (2005), pp. S42-S54.

4. Using data for development planning

678. Carrying out surveys for development planning can potentially produce powerful material for public knowledge, but the effectiveness of the results depends on the capacity of Governments, local academics and NGOs to analyse and use the data for decision-making; this is an area of continuing challenge in development countries.

679. A high percentage of countries (88 per cent) reported in the global survey having carried out research on population dynamics for planning purposes during the previous five years (the Americas, 94 per cent; Africa, 92 per cent; Europe, 88 per cent; Asia, 85 per cent; Oceania, 71 per cent), yet only 49 per cent of countries had produced a report covering the national and subnational levels.

680. The undertaking of periodic situation assessments in key areas allows countries to determine present and future needs across different sectors and population groups and represents the basis for improved targeting of public policy. While the proportion of countries that had conducted sectoral or population-based situation assessments during the previous five years varied according to the theme and region explored, the issue of coverage remains a concern, since few countries have developed an assessment covering both the national and the subnational levels (see table 4).

Table 4
Situation assessments conducted by theme, region and coverage

	Proportion of countries in each region that have conducted an assessment, either at the national level, subnational level or both (per cent)						*Proportion of countries that have conducted an assessment covering both the national and subnational levels (per cent)*
Theme	*World*	*Africa*	*Americas*	*Asia*	*Europe*	*Oceania*	*World*
Needs of adolescents and youth	83	79	94	88	86	64	35
Needs of older persons	66	57	72	69	90	23	15
Needs of persons with disabilities	75	65	69	82	94	54	18
Needs of indigenous peoples	60	55	88	50	44	40	15
Internal migration and/or urbanization	73	54	84	80	95	62	28
International migration and development	63	59	77	72	59	23	15
Family, its needs and composition	75	64	80	80	93	54	26
Sexual and reproductive health and reproductive rights	83	87	78	77	85	93	35
Unmet need for family planning	67	83	63	74	39	64	27
Gender equality and empowerment of women	86	87	91	88	97	46	29
Education	93	92	94	98	93	86	36

Source: International Conference on Population and Development beyond 2014 global survey (2012).

681. Given the centrality of equality to the goals of the International Conference on Population and Development, a core recommendation in the Programme of Action was that, in principle, all relevant social and health data should be appropriately

disaggregated by relevant factors such as age, sex, ethnicity, locality and wealth, in order to increase understanding of disparities in social development and enable policymakers to redress inequalities. This was an issue that received considerable attention in the International Conference on Population and Development beyond 2014 regional reviews and outcomes. The household surveys described above all enable such disaggregation to varying degrees.

682. Studies that disaggregate data down to district level and that combine different data sources at that level for local planning purposes are particularly scarce in developing countries. There is also a scarcity of studies that analyse the effects of migration at the national, as well as the local, level. Governments may also have difficulties making realistic assessments of emerging population trends. Particularly notable has been the inadequate capacity to project and plan for the pace of urban growth.

683. **States should ensure adequate measures that allow monitoring of inequality in access to public services, accountability structures and information, including sampling that will enable stratification and comparisons by race and ethnicity, age (including youth and older persons) and household wealth, and with greater attention to spatial circumstances, especially those that reflect insecurity of place, such as slums or informal settlements, among recent migrants and internally displaced persons.**

5. Capacity strengthening

684. The most crucial deficiency within the knowledge sectors of developing countries may be that information, even when available, does not make its way into planning decisions. Sustained efforts have been made in the last two decades to improve the capacity of countries to produce and use quality statistics in planning and decision-making. These efforts are partly driven by increased demands for improved statistics to monitor the Millennium Development Goals and by an emerging culture of results-based management of international aid.[500] A critical role in the improvement of data availability has been played by international survey programmes, including demographic and household surveys, multiple indicator cluster surveys and Living Standard Measurement Study surveys, and the international support in planning and carrying out population censuses in the 2010 round. The main beneficiaries of these programmes were low-income countries with poor household survey programmes and inadequate coverage of civil registration. In some cases the investments did not necessarily reflect government commitments, raising concerns about the sustainability of data-related operations without international aid.[501]

685. Progress in statistical capacity has been noted, even in the poor countries.[502] According to a World Bank index of statistical capacity, the quality of statistics in the world improved from 52 in 1999 to 68 in 2009 (out of 100).[502] The number of countries with a national strategy for the development of statistics increased,[500] and

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[500] Partnership in Statistics for Development in the 21st Century (PARIS21), "Statistics for transparency, accountability, and results: a Busan Action Plan for Statistics" (November 2011).

[501] S. Chen and others, "Towards a post-2015 framework that counts: developing national statistical capacity"; Discussion Paper No. 1 (Partnership in Statistics for Development in the 21st Century (PARIS21), November 2013).

[502] Report of the World Bank on efforts in developing a plan of action on statistical development (see E/CN.3/2012/16).

statistical development has begun to receive a higher priority in national development programmes.[502] At the end of October 2011, 101 countries were participating in the IMF General Data Dissemination System.[502] The capacity to provide data for monitoring the Millennium Development Goals, for example, increased tremendously, although data for some of the indicators are based on estimates and modelling done by international agencies and not the countries themselves. In 2003, only 4 countries (2 per cent of 163 countries with information available) had two data points for 16-22 indicators; by 2006, this had improved to 104 countries (64 per cent) and by 2011, to 122 countries (75 per cent).[503]

686. Nevertheless, quality and coverage of baseline information, two issues highlighted in the Programme of Action, are still a concern. For example, gender statistics were assessed as insufficient and the measurement of migration as "least adequate". Two decades later, the availability of gender statistics has increased, but progress has been limited[504] and data are still largely missing for topics such as gender-based violence, time use, access to assets, finance and entrepreneurship.[500] Many countries still do not have the capacity to collect data or to integrate data from various sources in order to obtain reliable statistics on internal and international migration. Within the context of the Millennium Development Goals indicators, data on health outcomes are among the most lacking,[501] mainly due to weak civil registration and administrative sources of data. Data on poverty are often unavailable,[501] with only 17 sub-Saharan African countries having collected data to measure changes in poverty in the past decade.[500] The operational review shows that, in addition to the areas of concern mentioned here, other critical dimensions of sustainable development are either poorly measured or not measured at all in most countries, such as the extent of stigma or discrimination, the quality of education, access to health care among adolescents and youth, the quality of health care, and spatial inequalities other than crude dichotomies of urban versus rural.

687. A larger system-wide approach to capacity development, beyond responding to international data requests, is needed to ensure a sustainable national knowledge-based system relevant to national development priorities. In this regard, two objectives, highlighted in the Busan Action Plan for Statistics, stand out. First, better open access to statistics is essential for a transparent, accountable and effective Government; nevertheless, the call at the International Conference on Population and Development for greater accessibility is unfulfilled in many countries. Second, the integration of statistics in policy and decision-making, which remains weak across the developing world, needs to be addressed with an eye to long-term capacity, including better linkages between ministries and research universities within countries, career structures for retaining quality analysts in government service, and the development and investment in local independent centres of excellence that:

(a) Coordinate efforts between data producers, users and policymakers;

(b) Advocate for improved production and use of high-quality and timely statistics;

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[503] Report of the Secretary-General on development indicators for monitoring the Millennium Development Goals (E/CN.3/2012/29 and Corr.1).

[504] *The World's Women 2005: Progress in Statistics* (United Nations publication, Sales No. E.05.XVII.7).

(c) Design, implement and monitor national strategies for the development of statistics;

(d) Provide knowledge through data archiving and documentation.

688. **States should strengthen knowledge sectors within their planning ministries. States should integrate population dynamics into the planning and implementation of development initiatives within all sectors, and at national and subnational levels. If development investments are to be based on evidence of need, and of impact, then Governments need a social architecture that enables evidence to form the basis of public debate and policy and makes knowledge accessible to all persons, across and between all sectors of society, without exclusion.**

C. Creating enabling legal and policy environments for participation and accountability

1. Laws and policies

689. States have the obligation to adopt laws and implement policies that contribute to the realization of human rights. Establishing a legal and policy framework that creates an enabling environment, respects all human rights and eliminates discrimination is a fundamental part of ensuring that rights holders have a voice and are able to hold Governments and other responsible parties to account. Laws protecting freedom of expression, freedom of association and access to public information play a critical role in ensuring that the right to participate is free, active and meaningful, as set forth in the international human rights framework.

690. As constitutionalism and democratic forms of governance have expanded, legislators have become central actors in the implementation and evolution of the Programme of Action. However, despite increased dialogue among parliamentarians through the establishment of national, as well as regional, parliamentarian groups in support of the Programme of Action and the five international parliamentarians' conferences on the implementation of the Programme of Action held at the global level since 2002, the parliamentary process could be more effective in ensuring executive actions on related matters or in affecting public opinion in support of the Programme of Action. The potential of using the tools of parliamentary oversight, questioning, investigation, resolutions and control over budget allocations to ensure the implementation of the Programme of Action has been insufficiently exploited over the past two decades.

2. Inclusive participation

691. Participation that involves stakeholders and is underpinned by respect for the substantive freedoms of expression and assembly is the basis for inclusive, and thus more sustainable, development. The involvement of beneficiaries in the planning, design, implementation, monitoring and evaluation of policies and actions is a hallmark of inclusive, responsive and good government in and of itself, but it can also improve government accountability and the delivery of public goods and services. The Programme of Action recognized that "population-related policies, plans, programmes and projects, to be sustainable, need to engage their intended beneficiaries" (para. 13.2).

692. The broad consensus at the International Conference on Population and Development was the result of wide consultation in countries and regions, with the active participation of civil society. During the International Conference, there was not only a separate NGO forum, but also NGO representation in many national delegations. Through their active presence, civil society organizations, including women's groups and activists, were able to claim space and their voices were factored into the high-level policy discussions that dealt with their health and well-being.

693. The International Conference on Population and Development was groundbreaking in its recognition that peoples' agency is central to the exercise of human rights, including sexual and reproductive health and rights. The Programme of Action emphasized the need to involve those directly affected, including in particular those excluded as a result of discrimination, coercion or violence, in developing laws, policies and practices, with the aim of empowering individuals, especially women and girls, to more fully exercise their human rights. In this regard, a major achievement since 1994 has been the increased mobilization of a broad range of diverse civil society organizations, other non-governmental stakeholders and social movements around the Programme of Action to shape global, regional and national legal, policy and accountability frameworks on related issues. This development is essential to ensuring the ongoing realization of the results of the International Conference and an inclusive post-2015 development agenda.

694. Given the sensitive nature of some parts of the mandate of the International Conference on Population and Development, an appreciation of local cultures and a sustained engagement with cultural gatekeepers have enabled grass-roots and community ownership of sexual and reproductive health and reproductive rights. In turn, this mobilization "from within" has shown that it can be the tipping point towards successful processes that ultimately hold Governments accountable for the realization of these rights. To that end, the engagement of civil society actors (NGOs, academia, eminent cultural personalities, faith-based organizations and religious and traditional leaders), as well as, parliamentarians and the media has proven to be critical for progress.

695. As far as the participation of adolescents and youth is concerned, a new paradigm, based on the goals and objectives of the International Conference on Population and Development, has emerged that recognizes adolescents and youth as rights holders entitled to make informed and responsible decisions about issues that affect their lives, including their sexual and reproductive health and rights. This was widely acknowledged in resolution 2012/1 on adolescents and youth adopted by the Commission on Population and Development and the declaration adopted at the Global Youth Forum held in Bali, Indonesia (2012).

696. The mobilization of the HIV community is a good illustration of effective collective action as well as a driving force for the implementation of the Programme of Action. Partnerships involving civil society have been recognized as fundamental to realizing the demand of people living with HIV and other key populations for the protection of their rights to treatment, non-discrimination and participation. The leadership of civil society organizations has demonstrated the powerful contributions that civil society can make to transformational change and should be applied to enhance peoples' participation and empowerment in further fulfilment of the Programme of Action.

697. Important strides have also been made by indigenous peoples to ensure their inclusion and full participation in matters affecting their human rights. The

establishment of the United Nations Permanent Forum on Indigenous Issues in 2002 with the participation of indigenous peoples' organizations was instrumental for the adoption of the United Nations Declaration on the Rights of Indigenous Peoples (2007) and, since its inception, the Permanent Forum has issued numerous recommendations to advance the rights of indigenous peoples.

698. Special attention is needed to create and ensure an enabling and safe environment for human rights defenders working on human rights related to the Programme of Action, including watchdog organizations and service providers, so that they can work and express their views freely without fear of reprisals. For instance, in regard to sexual and reproductive rights, denials of freedom of association, assembly and expression of people who speak out about violations of those rights occur in some countries. Frontline service providers are often also human rights defenders who can face considerable obstacles in assisting individuals to realize their rights, for example through restrictions in funding, harassment and violence by State and non-State actors, and in some cases criminal penalties for providing life-saving services.

699. **States and the international donor community should provide financial and other necessary support for social accountability in order to sustain a diverse range of beneficiaries', citizens' and civil society organizations' capacities for, and involvement in, monitoring States' fulfilment of their human rights obligations through national policies, budgets, programming or other measures, and develop their capacity to engage with international and regional human rights mechanisms.**

700. **States should ensure that human rights defenders are protected in their work, including through the creation of an enabling environment, consistent with the Declaration on the Right and Responsibility of Individuals, Groups and Organs of Society to Promote and Protect Universally Recognized Human Rights and Fundamental Freedoms (Declaration on the Protection of Human Rights Defenders).**

Human rights elaborations since the International Conference on Population and Development

Box 28
Participation

Other soft law. Clarifying rights related to participation, general comment No. 25 on the right to participate in public affairs, voting rights and the right of equal access to public service (1996) adopted by the Human Rights Committee clarifies the "rights of every citizen to take part in the conduct of public affairs" and "the right of individuals to participate in those processes which constitute the conduct of public affairs". The Guiding Principles on Extreme Poverty and Human Rights (2012) highlight the importance of developing policies and programmes consistent with human rights principles and that encourage the participation of key populations in the design of relevant policies and programmes. "States should devise and adopt a poverty reduction strategy based on human rights that actively engages individuals and groups, especially those living in poverty, in its design and implementation. It should include time-bound benchmarks and a clear implementation scheme that takes into account the necessary budgetary

> implications. It should clearly designate the authorities and agencies responsible for implementation and establish appropriate remedies and grievance mechanisms in the event of non-compliance."

701. Government support for the inclusion of key population groups in decision-making processes varies considerably across regions, income groups and population groups themselves, as reported in the global survey. For instance, "instituting concrete procedures and mechanisms for adolescents and youth to participate" is a high priority, with more than three quarters of countries (76 per cent) having addressed this issue during the previous five years (see table 5). Although no major variations are observed across income groups, a higher proportion of countries in the Americas (88 per cent) addressed this issue. On the contrary, the same objective was addressed by only just over 47 per cent of countries in relation to older populations, although in the latter case the Americas (63 per cent) and Europe (56 per cent) are above the world average; this issue is addressed by a higher proportion of wealthier countries. The issue of "instituting concrete procedures and mechanisms for persons with disabilities to participate" was addressed by about 6 in 10 countries globally (61 per cent), but the proportion falls below the world average in Oceania and Africa. Generally, a higher proportion of richer countries addressed this issue than poorer countries.

702. If a composite indicator is created for these three groups of beneficiaries, results show that out of the 129 countries with complete data, only 39, or 30 per cent, have addressed the participation of youth, older persons and persons with disabilities. In fact, 15 countries, or 12 per cent, have not addressed the participation of any of these populations in the planning, implementation and evaluation of development activities.

Table 5

Percentage of Governments addressing political participation, by population group

	Population group			
Indicator	*Adolescents and youth*	*Older persons*	*Persons with disabilities*	*Indigenous peoples*
Addressing political participation, world	76.3%	47.2%	60.7%	57.5%

Source: International Conference on Population and Development beyond 2014 global survey (2012).

703. Approximately half of all reporting countries had addressed the issue of "instituting concrete procedures and mechanisms for indigenous peoples to participate" (58 per cent) (table 5). This may reflect, in part, that not all countries include a defined population of "indigenous persons" that is distinct from the majority population. Nonetheless, fewer than half of African countries (36 per cent) addressed this issue during the previous five years, while over or close to two thirds of countries in the Americas (75 per cent), Asia (71 per cent) and Oceania (86 per cent) had done so.

Case study — Urban transformation via participation

Brazil[505]

The Programme of Action recognized the importance of increasing participation in governance and, in the subsequent decades, the combination of decentralization and the emergence of powerful mechanisms of direct participation in local governance has been instrumental in Brazil. One of the most prominent global examples is participatory budgeting in municipalities, which has also been applied to slum upgrading efforts in Brazil's favelas.

In 2001, Brazil adopted the Statute of the City (*Estatuto da Cidade*), a major advance in the democratization of urban planning and governance. It has two key components: prioritizing social versus commercial functions of urban land and buildings, and institutionalizing participatory and democratic city management. This statute extends participatory budgeting, which emerged from the grass-roots level in Porto Alegre in the late 1980s and has since expanded to more than 200 cities in Brazil (as well as to cities around the world). Key elements include diverse community participation, institutionalization of the approach through scheduled meetings between local government and community groups, and effective assignment of a portion of the city's budget to the outcome of the process. Recent research comparing matched pairs of municipalities in Brazil — one that did and one that did not institute participatory budgeting — suggests that it has had appreciable impact on enhancing equality.[506]

These approaches have been extended to slum-upgrading efforts. *Favelas-Bairro* is an upgrading programme started in 1994 to reunite Brazil's divided cities. The objective was social and physical integration of all low-income neighbourhoods into the formal urban fabric of Rio de Janeiro by 2020. The key difference in this effort relative to conventional poverty reduction policies was the use of unique legislative reforms. These legislative reforms made it possible for local authorities, through existing community programmes, to support the "right to use but not own" land. The use of design as a core project strategy for social and physical integration was a success on the whole, but the project has also shown that structural upgrades cannot reduce crime on their own; improving facilities leads to the threat of gentrification and governance is critical, or corrupt representation can erode the participatory process.

704. **States should guarantee and facilitate the participation of non-State actors, including the intended beneficiaries, in policy and programme development, implementation and evaluation. In doing so, States should pay particular attention to adolescents and youth, representing all education and**

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[505] G. Martine and G. McGranahan, "Brazil's early urban transition: what can it teach urbanizing countries?" (International Institute for Environment and Development and United Nations Population Fund, 2010).

[506] G. Baiocchi, P. Heller and M. K. Silva, *Bootstrapping Democracy: Transforming Local Governance and Civil Society in Brazil* (Stanford, California, Stanford University Press, 2011).

income sectors of society, and ensure and facilitate their participation in policy and programme development, implementation and evaluation, particularly in matters that affect them. This should intentionally be extended to include representatives of those living in poverty, groups who frequently experience discrimination, and other intended beneficiaries of development.

3. Remedies and redress

705. All victims of human rights violations have a right to an effective remedy and to reparations. Ensuring accountability not only requires responding to human rights violations that have occurred, but also identifying systemic failures and the necessary corrective actions. States must also be held responsible for acts committed by private actors if the State fails to prevent violations of rights or to investigate and punish actions and omissions committed by non-State actors.

706. National institutions, such as courts, administrative review bodies and parliaments, among others, have direct obligations that emanate from human rights law, as part of the State that is party to human rights treaties. The judiciary, when adequately resourced and sensitized, can play a crucial role in ensuring justice for human rights violations. However, in many parts of the world these mechanisms are not accessible to many victims of human rights violations because of geographic, economic and social factors.

707. **States should ensure access to remedies and redress to victims of human rights violations. To ensure the effective use of remedies, the State should systematically raise awareness about the applicability of claims relating to human rights among lawyers, judges and the public, and provide adequate funding for accountability mechanisms. States should combat impunity by increasing access to justice, so that aggrieved individuals have access to remedies and reparations that encompass restitution, rehabilitation, measures of satisfaction and guarantees of non-repetition, where appropriate. Special mechanisms need to be put in place to ensure access for rural and underserved communities, as well as for people in conflict, post-conflict and humanitarian situations and fragile contexts.**

708. At the international level, accountability mechanisms have been strengthened in the past 20 years as mechanisms for redress. States, the United Nations and civil society, among other crucial actors, have established many positive examples of engagement with international human rights mechanisms such as treaty bodies and special procedures of the Human Rights Council, and the expert opinions from those bodies have further enhanced the reinforcement of human rights obligations related to the Programme of Action. The universal periodic review of the Human Rights Council, established in 2006, is also an important accountability mechanism for States to realize the human rights commitments made at the International Conference on Population and Development. International accountability requires systematic integration of information on human rights related to the Programme of Action into reports submitted to these international human rights mechanisms, together with information on the implementation of recommendations made by these entities. The regular dialogues between the committees and States parties, and the individual complaints procedures of the various committees, contribute to ensuring State accountability, while the Committees' general comments and recommendations clarify the nature and extent of States' obligations to guarantee human rights.

709. **States should ratify international and regional human rights treaties, and remove reservations to treaty provisions, relevant to all dimensions of dignity, including gender equality, non-discrimination, sexual and reproductive health and rights, security of place, mobility and political participation. States should harmonize national laws with international instruments and monitor the extent to which human rights are respected, protected, promoted and fulfilled, and ensure that human rights protection mechanisms are in place. This should include the development of legislation and administrative practices to regulate, control, investigate and prosecute actions by non-State actors that violate human rights.**

D. Collaboration, partnerships and coherence

710. International cooperation has proven essential for the implementation of the Programme of Action during the past two decades. Such cooperation takes various forms, including multilateral, bilateral, regional, interregional, South-South and triangular cooperation. Efforts to ensure effective donor coordination under national ownership at country level have drawn attention to the negative impact of conditionality and the need to improve development effectiveness and reduce transaction costs, including through coherence between donor assistance and national priorities, capacity development and aid exit strategies. Since 1994, the number of financial donors has steadily increased and the profile of the donor community has increasingly been shaped by the growing presence of non-governmental and private-sector organizations.[507] As mentioned above, partnerships with civil society actors have been instrumental in moving the implementation of the Programme of Action forward on the ground, against the background of an increasingly complex aid environment, with new stakeholders and partnerships for development and a number of mechanisms seeking to coordinate donor contributions in sectoral and national planning processes.

Human rights elaborations since the International Conference on Population and Development

Box 29

Collaboration, partnerships and coherence

Intergovernmental human rights outcomes. In resolution 61/160 (2006) on the promotion of a democratic and equitable international order, the General Assembly affirmed that "the enhancement of international cooperation for the promotion and protection of all human rights should continue to be carried out in full conformity with the purposes and principles of the Charter of the United Nations and international law". In 2008 the Human Rights Council adopted resolution 8/5 on the same subject, with similar wording. Building on the triennial comprehensive policy review, the General Assembly adopted, without a vote, resolution 67/226 (2012) on the quadrennial comprehensive policy review of operational activities for development of the United Nations system, in which the Assembly promoted enhanced system-wide coherence that recognizes the value of improving linkages between operational activities and norms and standards such as freedom, peace, security and human rights and the importance of mainstreaming sustainable development into the mandates, programmes, strategies and decision-making processes of United Nations entities.

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[507] J. S. Singh, *Creating a New Consensus on Population: The Politics of Reproductive Health, Reproductive Rights and Women's Empowerment*, 2nd ed. (London, Earthscan, 2009).

1. Multilateral response to the Programme of Action

711. The Programme of Action has been adopted as a framework by multilateral institutions since 1994; it influenced the conception of the Millennium Development Goals. As the organs and bodies of the United Nations system have sought to integrate the Programme of Action into resolutions and outcomes on economic, social and environmental matters, the entities of the United Nations system, including the World Bank, have worked cooperatively to reflect this integration through thematic groups, country-level thematic and United Nations programming frameworks, as well as through coordination under the United Nations Development Group and the United Nations Chief Executives Board for Coordination. Through the regular refinements of the General Assembly triennial — now quadrennial — comprehensive policy review and the emerging "Delivering as one" approaches, as well as joint programming and multi-donor funding modalities, the population and development agenda has been further integrated into both analysis and programming for multilateral assistance. The European Commission, as a funding and policy player in its own right, has championed support for the implementation of the Programme of Action.

712. UNFPA has played a convening role in promoting the Programme of Action through the adoption of global, regional and country programmes focused on key aspects, resulting in policies, programmes and services in all regions. Since 1994, targeted funding has been provided to UNFPA country programmes in more than 130 countries in all regions to promote and implement human rights-based population policies and programmes.

713. In response to the Programme of Action, WHO decreased its research emphasis on generating entirely new methods of contraception to include a broader research agenda on sexual and reproductive health conditions, and the technologies, norms and standards for a woman-centred and rights-based delivery of sexual and reproductive health services.

714. The Office of the United Nations High Commissioner for Human Rights (OHCHR) has continuously worked to ensure that international human rights standards build upon and strengthen the Programme of Action, through the work of treaty bodies and other expert mechanisms.

715. The United Nations Population Division has played an active role in the intergovernmental dialogue on population and development, producing updated demographic estimates and projections for all countries, including data essential for the monitoring of progress in the implementation of the Programme of Action, developing and disseminating new methodologies and, alongside UNFPA, preparing reports for the annual sessions of the Commission on Population and Development.

716. At the regional level, the United Nations regional commissions, notably the Economic Commission for Latin America and the Caribbean, have promoted the Programme of Action by revitalizing their social components and centres of excellence to address emerging population issues and improve the capacity of

Governments to respond to them through national policies aimed at development and human rights.

717. Multilateral financial institutions like the World Bank, the Asian Development Bank and the Inter-American Development Bank have supported programmes such as the conditional cash transfer programmes, hotline services for reporting gender-based violence and youth-friendly services, including health services for women, consistent with the goals and objectives of the International Conference on Population and Development. In many countries the United Nations has worked in collaboration with donors and financial institutions to enable Governments to conduct censuses and to help countries integrate population dynamics into development plans, affecting a wide range of policies and decision-making in all regions.

2. Intergovernmental follow-up

718. The Programme of Action, and the key actions for its implementation adopted five years later, has been reaffirmed by the international community at major United Nations conferences and summits, including the Fourth World Conference on Women in 1995, the Millennium Summit of the United Nations in 2000, the 2005 World Summit, the High-level Plenary Meeting of the General Assembly on the Millennium Development Goals in 2010 and the United Nations Conference on Sustainable Development in 2012.

719. The General Assembly, the Economic and Social Council and its subsidiary bodies, such as the Commission on Population and Development, the Commission on the Status of Women, the Commission for Social Development and the Commission on Sustainable Development; and the Security Council have since 1994 adopted resolutions and other outcomes on all aspects of the population and development agenda. These outcomes have reinforced the links between human rights and development; women, peace and security; zero tolerance for gender-based violence, including the human rights of all women to have control over and to decide freely and responsibly on matters related to their sexuality, free of coercion, discrimination and violence; as well as the need to protect the human rights of adolescents and youth to have control over and to decide freely and responsibly on matters relating to their sexuality, including sexual and reproductive health, regardless of age and marital status, among other factors.

720. There have been significant developments at the Human Rights Council, which adopted resolutions on maternal mortality and morbidity and human rights in the period 2009-2012[508] and resolution 17/19 on human rights, sexual orientation and gender identity in 2011.

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[508] The Human Rights Council has adopted several resolutions on maternal mortality and human rights, including resolution 18/2 of 28 September 2011 on preventable maternal mortality and morbidity and human rights (see A/66/53/Add.1, chap. II), in which it recognized that a human rights-based approach to eliminate preventable maternal mortality and morbidity is an approach underpinned by the principles of, inter alia, accountability, participation, transparency, empowerment, sustainability, non-discrimination and international cooperation and encouraged States and other relevant stakeholders, including national human rights institutions and non-governmental organizations, to take action at all levels to address the interlinked root causes of maternal mortality and morbidity, such as poverty, malnutrition, harmful practices, lack of accessible and appropriate health-care services, information and education, and gender inequality, and to pay particular attention to eliminating all forms of violence against women and girls.

3. South-South cooperation and triangular cooperation

721. The Programme of Action refers to South-South cooperation as an important instrument for development and objective of resource mobilization. Subsequent summits and conferences have shaped the framework for South-South cooperation, including the South Summit, held in Havana in 2000; the High-level Conference on South-South Cooperation, held in Marrakech, Morocco, in 2003; the Second South Summit, held in Doha in 2005; and the High-level United Nations Conference on South-South Cooperation, held in Nairobi in 2009. The framework of operational guidelines on United Nations support to South-South and triangular cooperation (SSC/17/3) highlights the key role that United Nations organizations can play in improving South-South knowledge sharing, networking, information and best practice exchanges, policy analysis and coordinated actions on major issues of concern.

722. Many middle-income countries have become active proponents of South-South partnerships. Emerging economies have made significant investments in South-South cooperation. Traditional donors have recognized the value of South-South cooperation as well. This has reinforced South-South cooperation as a horizontal learning mechanism, well placed to boost the development of national capacities as well as promote triangular mechanisms that fund South-South partnerships with contributions from donor Governments.[509]

723. An example of a South-South and triangular initiative enabling national institutions to promote horizontal cooperation in areas related to the Programme of Action is the intergovernmental organization Partners in Population and Development, established to promote South-South cooperation in the field of reproductive health, population and development. Over the past two decades the organization's annual interministerial conferences have provided a peer review mechanism for the member countries on all aspects of population and development issues.

4. Changes in the global burden of disease and corresponding aid

724. Since the adoption of the Programme of Action, the architecture for development cooperation has also been shaped by the response to the global crisis in HIV and AIDS, which has had a profound impact on the operational structure of new donor initiatives, for example, the Global Fund to Fight AIDS, Tuberculosis and Malaria; the scale of donor support for a single, albeit complex, health condition, for example, the Emergency Plan for AIDS Relief of the President of the United States, the scale of which has eclipsed many national health budgets; and an acute concentration of donor support to Africa owing to the exceptionally high burden HIV and AIDS in that region.

725. The scale of the epidemic and corresponding HIV- and AIDS-related resource flows heightened global political commitments to health[510] and dramatically increased recipient countries' capacity to roll out HIV prevention and HIV and AIDS treatment. In countries where global health initiatives — the main funders of single-disease programmes — were well aligned with country priorities, HIV-related aid proved effective in strengthening the health system, promoting leadership and advocacy for HIV and AIDS, and led to unusual and sometimes innovative

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[509] Report of the Third United Nations Conference on the Least Developed Countries, Brussels, 14-20 May 2001 (A/CONF.191/13).

[510] Yu and others, "Investments in HIV/AIDS programs: does it help strengthen health systems in developing countries?" (see footnote 342 above).

partnerships between health departments and other sectors of government for HIV prevention, e.g., the transport, defence and education sectors.[511]

726. However, in countries where global health initiatives have fostered an environment of fragmented and uncoordinated aid and donor competition, the scale of HIV-related aid exacerbated problems. Recipient countries were unable to predict their annual health budget from one year to the next, and were beholden to donor interests and priority projects that focused on HIV and AIDS rather than health sector-wide investments.[512] Countries were often held accountable to strict and focused HIV-related donor reporting frameworks, expending valuable resources to track aggregate coverage-based indicators, which can mask gross disparities in quality of care.

727. High levels of vertical HIV funding also led to a rapid proliferation of NGOs implementing HIV programmes in developing countries, some of which were highly effective agents of change, but some of which were not. Unregulated and unsupervised NGOs led, in some cases, to an exodus of health workers from the public sector to NGOs, improving employment opportunities, but also undermining the capacity of the local public primary health system.[513] In combination with a weak public sector, health services delivered by single-issue NGOs forced patients to navigate a complex network of uncoordinated services, often causing interruptions in the continuity of care and supply of essential medicines and limiting the systematic or comprehensive care of patients' health needs.[514]

728. Since 2000, increased attention has been devoted to aid effectiveness, prompted in part by frustrations of developing country over problems of unequal aid partnerships and the loss of their ability to effectively plan, coordinate and lead the development process in their own country. In the 2001 Abuja Declaration on HIV/AIDS, Tuberculosis and Other Related Infectious Diseases, States members of the African Union committed to increasing health spending to at least 15 per cent of the national budget, and called upon donor countries to scale up support accordingly.

729. The outcomes of the High-Level Forums on Aid Effectiveness (the Paris Declaration on Aid Effectiveness of 2005, the Accra Agenda for Action of 2008 and the Busan Partnership for Effective Development Cooperation of 2011), strengthened commitments to deliver aid more effectively, with an emphasis on capacity development and national ownership and execution. The increasing importance of the aid effectiveness agenda has been reflected in the development of structures for donor coordination, and greater acknowledgement of country leadership and mutual accountability in these collaborations. A WHO-UNFPA multi-

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[511] N. Spicer and others, "National and subnational coordination: are global health initiatives closing the gap between intent and practice?", *Globalization and Health*, vol. 63, No. 3 (2010); R. G. Biesma and others, "The effects of global health initiatives on country health systems: a review of the evidence from HIV/AIDS control", *Health Policy and Planning*, vol. 24, No. 24 (2009), pp. 239-252.

[512] M. Martínez Álvarez and A. Acharya, "Aid effectiveness in the health sector", Working Paper No. 2012/69 (Helsinki, United Nations University, World Institute for Development Economics Research, 2012).

[513] J. Pfeiffer and others, "Strengthening health systems in poor countries: a code of conduct for nongovernmental organizations", *American Journal of Public Health*, vol. 98, No. 12 (2008), pp. 2134-2140.

[514] Ibid.; J. Pfeiffer, "International NGOs and primary health care in Mozambique: the need for a new model of collaboration", *Social Science and Medicine*, vol. 56, No. 4 (2003), pp. 725-738.

country assessment study[515] of the implications of recent changes in the aid environment for sexual and reproductive health policy development and programming found that organizational engagement at the country level was increasingly characterized by a focus on sector-wide approaches and poverty-reduction strategies, as well as on strategizing to achieve the Millennium Development Goals, in particular goals 4 and 5 (targets A and B). The latter was found to have resulted in an increased awareness of issues around maternal and newborn health, while other aspects of sexual and reproductive health were found to have been marginalized, in terms of both country priorities and donor support.[515]

730. The study also found that secure, predictable funding for sexual and reproductive health remains a problem, and much of the funding for activities are still donor dependent. Multisectoral approaches to sexual and reproductive health programmes were found to have remained largely underdeveloped in the countries that were part of the assessment study. Yet the shift towards health-system strengthening and support through the International Health Partnership and other related initiatives was reported to offer a framework within which sexual and reproductive health could be more broadly addressed.

5. New global partnerships

731. Recent years have seen a proliferation of new initiatives, partnerships, and formal and informal cooperation and coordination mechanisms involving United Nations agencies and others, established to accelerate concerted efforts to implement certain parts of the Programme of Action.

732. These include, among others, United Nations Action against Sexual Violence in Conflict, an inter-agency group consisting of 12 United Nations agencies, which provides support to the Secretary-General's campaign UNiTE to End Violence against Women. The UNFPA-UNICEF joint programme on female genital mutilation-cutting supports 17 countries, as of 2014, with the aim of reducing and eliminating this harmful practice. The United Nations Inter-Agency Task Force on Adolescent Girls was established to coordinate work among agencies to address the needs of this particular population group, with special emphasis on marginalized girls, including those at risk of child marriage. The Campaign to End Fistula is active in countries to provide support for fistula prevention, as well as treatment and social reintegration for those who have suffered this severe condition.

733. The Action 2 programme was set up in response to a call by the Secretary-General for joint United Nations action to strengthen human rights-related actions at the country level and enhance support for the establishment and strengthening of national human rights promotion and protection systems consistent with international human rights norms and standards. The initiatives have worked to integrate human rights throughout the United Nations system in all its humanitarian, development and peacekeeping work, and promoted a human rights approach to programming. In 2009, in the framework of the implementation of the Secretary-General's Policy Committee decision on human rights and development, the United Nations Development Group endorsed the establishment of the human rights

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[515] WHO and UNFPA, "Strengthening country office capacity to support sexual and reproductive health in the new aid environment: report of a technical consultation meeting: wrap-up assessment of the 2008-2011 UNFPA-WHO collaborative project" World Health Organization, document WHO/RHR/11.29.

mainstreaming mechanism to reinforce the accomplishments of the Action 2 programme.

734. In the area of health, the International Health Partnership is scaling up efforts to advance the health-related Millennium Development Goals. The Partnership is strengthening national processes in 21 countries in Africa and Asia with a focus on revitalizing health systems. Health Four Plus (H4+) is a joint effort by UNAIDS, UNFPA, UNICEF, the United Nations Entity for Gender Equality and the Empowerment of Women (UN-Women), WHO and the World Bank. The global Partnership for Maternal, Newborn and Child Health, which was launched in 2005, provides a forum through which members can combine their strengths and implement solutions.

735. The Reproductive Health Supplies Coalition, a global partnership of multilateral and bilateral organizations, private foundations, Governments, civil society and private-sector representatives, was established with the goal of ensuring that all people in low- and middle-income countries can access and use affordable, high-quality contraceptives and other reproductive health supplies. More recently, Family Planning 2020 has been building on the partnerships launched at the London Summit on Family Planning organized by the Government of the United Kingdom and the Bill and Melinda Gates Foundation, in partnership with UNFPA; it brings together national Governments, donors, civil society, the private sector, the research and development community and others from around the world to provide 120 million more women and girls in the world's poorest countries with access to voluntary family planning information, contraceptives and services by 2020.

736. In the area of international migration, United Nations agencies and the International Organization for Migration (IOM) collaborate and coordinate efforts in the Global Migration Group to promote the wider application of all relevant international and regional instruments and norms relating to migration, and to encourage the adoption of more coherent, comprehensive and better-coordinated approaches to the issue of international migration.

737. The Partnership in Statistics for Development in the 21st Century (PARIS21) was founded in 1999 by the United Nations, the European Union, the Development Assistance Committee (DAC) of OECD, IMF and the World Bank, in response to a perceived need to address the reduction of poverty and the improvement of governance in developing countries by promoting the integration of statistics and reliable data in the decision-making process. In its most recent plan, adopted in Busan, Republic of Korea, in 2011, PARIS21 adopted a system-wide approach to capacity development to integrate national statistical activities with the requirements of planning, budgeting, monitoring and results, and recognized the important synergies between survey- and census-based data, administrative data and vital statistics. The Busan Action Plan for Statistics also explicitly supports greater transparency and encourages the use of new methods and technologies to increase the reliability and accessibility of statistics. It explicitly recognizes the statistical activities necessary to support key global commitments, including on initiatives such as gender equity and the empowerment of women.

738. Coordination and partnerships are essential to address the complex challenges of sustainable development in an increasingly globalized world. Such partnerships also hold promise for broad public accountability, if initiatives and mechanisms are not "owned" by a particular group of Governments, foundations or international civil servants, and for ensuring that scarce development funds are not wasted through fragmentation or duplication of efforts.

E. Financial resource flows

739. In the global survey, 88.8 per cent of countries reported having allocated resources to "monitor population trends and prepare population projections/scenarios" during the preceding five years; in European countries the proportion reached 100 per cent. Over 86 per cent of countries reported having earmarked resources to explore "linkages between population and poverty".

1. Donor aid for selected components of the Programme of Action

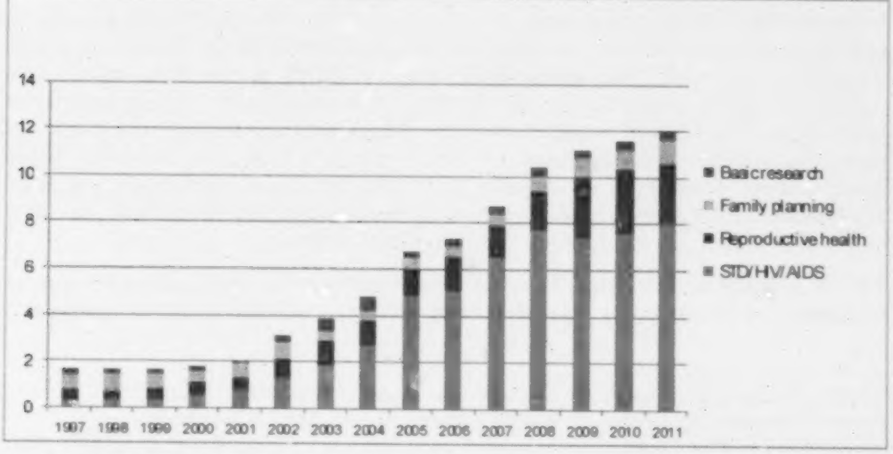
740. At the International Conference on Population and Development, the international community agreed that US$ 17 billion would be needed in 2000, $18.5 billion in 2005, $20.5 billion in 2010 and $21.7 billion in 2015 to finance four core programmes in the area of population and development: family planning; basic reproductive health; prevention of sexually transmitted diseases, including HIV/AIDS; and programmes that address the collection, analysis and dissemination of population data. Two thirds of the required amount would be mobilized by developing countries themselves and one third — $5.7 billion in 2000, $6.1 billion in 2005, $6.8 billion in 2010 and $7.2 billion in 2015 — was to come from the international community.

741. Routine monitoring of funding for components of the Programme of Action related to sexual and reproductive health has been sustained over time, and shows a steep increase in donor assistance since 2004 for HIV- and AIDS-related activities. The largest proportion of population assistance — 66 per cent in 2011 — went to activities related to prevention of sexually transmitted infections/HIV/AIDS, the majority of which was allocated to HIV/AIDS (see figure 55). A total of 8 per cent of population assistance was expended for family planning services, 22 per cent for basic reproductive health services and 4 per cent for basic research, data, and population and development policy analysis.

Figure 55

Donor expenditures for four components of the Programme of Action, 1997-2011

(Billions of United States dollars)



Source: UNFPA, *Financial Resource Flows for Population Activities in 2011* (New York, 2013) and Resource Flows Project database.

742. Funding for the four areas has increased in absolute dollar amounts, but HIV/AIDS activities received an increase of 27 times the funding allocated for this component in 1997. Financial flows to reproductive health activities have increased as well, although less dramatically. The amount of money allocated to reproductive health was 22 per cent of the total assistance for this activity in 2011. Sub-Saharan Africa, where the majority of the assisted least developed countries are located, has been the recipient of the largest amount of aid, receiving about two thirds of such assistance going to the five geographic regions;[516] this reflects the high level of need in the region for all the dimensions of sexual and reproductive health, but particularly HIV and AIDS.

743. Although funding for population activities has been rising, it has not been meeting growing needs in developing countries. To ensure adequate funding for the implementation of these components of the Programme of Action (para. 13.14), in 2009 UNFPA reviewed the estimates for the four components and revised them to reflect current needs and costs. The revised estimate across the four components totalled $64.7 billion for 2010, which was expected to rise to $69.8 billion by 2015.[517] These revised estimates are much higher than the original targets agreed upon in 1994 because they take into account both current needs and current costs, and include interventions such as AIDS treatment and care and reproductive cancer screening and treatment, which were not part of the original costed package. The revised costs are considered minimum estimates of the funds required to finance interventions to meet growing needs for the four components. Further revisions may now be warranted on the basis of the findings of the operational review.

744. Systematic monitoring of donor aid for the implementation of the Programme of Action has not been carried out in a manner that embraced its full, far-ranging objectives and actions, for example, human rights, violence, the social protection of migrants and research on climate change, among others; in any case, it would be challenging to formulate estimates for each activity, as they would likely reach across multiple development sectors.

2. Bilateral support

745. OECD/DAC donor countries have played an essential role in supporting the implementation of the Programme of Action worldwide by supplementing domestic resources, in particular for sexual and reproductive health in developing countries, with family planning, safe motherhood and HIV/AIDS as the three main areas receiving funding. Nevertheless, the funding, in terms of what was agreed at the International Conference, is insufficient to address national and regional needs. In particular, family planning information and services have slid far down the public policy agenda; funding for surveillance of sexually transmitted infections is grossly inadequate; and primary health-care systems need substantial investment, to name only a few of the gaps identified in the operational review.

746. The nature of donor support and funding structures has not always been geared to support of integrated or holistic service delivery. Existing family planning and

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[516] UNFPA, *Financial Resource Flows for Population Activities in 2011* (New York, 2013).

[517] Report of the Secretary-General on the flow of financial resources for assisting in the implementation of the Programme of Action of the International Conference on Population and Development (E/CN.9/2009/5); UNFPA, *Revised Cost Estimates for the Implementation of the Programme of Action of the International Conference on Population and Development: A Methodological Report* (New York, 2009).

maternal and child health programmes and institutional structures continue to be the object of strong donor commitment, as they have often been supported and built up by donors over many years. These programmes, however, still lack vertical accountability, which tends to perpetuate programme-specific flows of funding, management, commodities, logistics, reporting and so on. This "silo" funding and vertical orientation is contrary to stated donor and government policy goals to provide integrated service delivery and strengthen the long-term capacity and growth of the health sector, as agreed to in the Programme of Action. Despite all good intentions, such vertical approaches may have been exacerbated by the establishment of vertical funding mechanisms such as the Global Fund to Fight AIDS, Tuberculosis and Malaria (2000).

3. Domestic expenditures

747. Domestically generated financial resources, which include government, national NGO and private out-of-pocket expenditures, account for the majority of funding for the costed components of the Programme of Action. Although much harder to measure, it is estimated that developing countries and countries in transition mobilized $54.7 billion for population activities in 2011, the largest amount ever. The considerable increase over previous years is due in part to the large expenditures reported for family planning in China, but the latest numbers may not be entirely comparable to past estimates owing to the inclusion of new data on out-of-pocket expenditures from WHO (see table 6).[516]

Table 6

Estimates of global domestic expenditures for four components of the Programme of Action, 2011

(Thousands of United States dollars)

	Source of funds				
Region	*Governments*	*NGOs*	*Consumers*[a]	*Total*	*Percentage spent on sexually transmitted diseases HIV AIDS*
Africa (sub-Saharan)	3 244 374	119 916	3 567 490	6 931 780	95%
Asia and the Pacific	11 249 700	157 910	27 944 254	39 351 864	10%
Latin America and the Caribbean	2 190 262	80 799	1 133 654	3 404 715	85%
Western Asia and North Africa	542 511	60 014	349 920	952 445	36%
Eastern and Southern Europe	2 669 365	16 025	1 374 723	4 060 113	96%
Total	**19 896 212**	**434 664**	**34 370 040**	**54 700 916**	**32%**

Source: UNFPA, *Financial Resource Flows for Population Activities in 2011* (New York, 2013). See also Erik Beekink, Projections of Funds for Population and AIDS Activities, 2011-2013 (The Hague, Netherlands Interdisciplinary Demographic Institute, 2013).

[a] Consumer spending on population activities covers only out-of-pocket expenditures and is based on the average amount per region measured by WHO for health-care spending in general. For each region, the ratio of private out-of-pocket to per capita government expenditures was used to derive consumer expenditures in the case of population activities.

748. Developing countries as a whole are currently funding over three fourths of the expenditures of the population package costed under the Programme of Action. However, most domestic resource flows originate in a few large developing countries. The majority of developing countries have limited financial resources to utilize for population and reproductive health programmes and cannot generate the required funds to implement these programmes, relying largely on donor assistance instead. Moreover, private consumers in developing countries account for over half of domestic resources through out-of-pocket expenditures. This has important implications with regard to access, reaching the most marginalized and slow progress in achieving targets. It also has important implications for policy initiatives aimed at reducing poverty and income inequality in the developing world.[517]

Human rights elaborations since the International Conference on Population and Development

Box 30
Resource flows

Other intergovernmental outcomes. The Monterrey Consensus of the International Conference on Financing for Development reflects a commitment to international development cooperation. The Consensus states, "Good governance is essential for sustainable development. Sound economic policies, solid democratic institutions responsive to the needs of the people and improved infrastructure are the basis for sustained economic growth, poverty eradication and employment creation. Freedom, peace and security, domestic stability, respect for human rights, including the right to development, and the rule of law, gender equality, market-oriented policies, and an overall commitment to just and democratic societies are also essential and mutually reinforcing."

F. The beyond 2014 monitoring framework

749. In the two decades since 1994 there has been a multiplication of efforts to measure the evolution of human rights protection systems, develop new indicators of gender equality and empowerment, appraise the quality of sexual and reproductive health services, and define national and global indicators of human development, such as those developed for measuring progress towards the Millennium Development Goals. Most of these efforts, the Millennium Development Goal framework project included, have garnered ample criticism, but by virtue of being tested and evaluated, they provide a foundation for monitoring agreed goals beyond 2014.

750. The beyond 2014 monitoring framework will provide a basis for national and global reporting on progress that can enhance the review and appraisal of the implementation of the Programme of Action by the General Assembly, the Economic and Social Council and the Commission on Population and Development. Both the global "score card" and the global report will provide readily available input for any monitoring under the post-2015 development agenda. Reporting on commitments related to the Programme of Action in the treaty bodies or in the intergovernmental bodies of the United Nations, separately or independently will be

more easily integrated into the processes of the Commission on Population and Development.

G. Governance and accountability: key areas for action

1. Population dynamics data are critically important for development planning.

751. Population dynamics must not be regarded as numeric abstractions but as foundational data on the human experience, including how the characteristics of people affect the potential for development, how they interact with their environment, where they are living or moving, whether or not they are well or living with fear and insecurity, and what social protections and public services they may need. Population dynamics today underscore the world's dramatic demographic disparities and varied trends: rising numbers of older persons worldwide, a process most advanced in Europe and parts of Latin America and Asia; young populations and continued high fertility in Africa; and the changing nature of households in many regions, with increasing proportions of one-person and single-parent households. The capacity to monitor and project population dynamics must be a core investment for development, informing the response to where and how best to invest development resources and promote human rights and dignity.

2. Knowledge sectors need strengthening.

752. The operational review highlighted considerable weaknesses in the knowledge sector in population and development in countries, including inconsistent civil registration and censuses and limited use of innovations, but especially in the generalized low capacity for using data for development planning, implementation, monitoring and evaluation. There is a pressing need to strengthen capacity in demography, public health, human rights and economics and related social sciences, and to improve productive linkages between researchers, development planners and ministries, allowing nationally generated data to foster knowledge-driven governance.

753. Strengthened leadership is required in overall planning for the knowledge sector, including resource allocation and investments in human resources. Pressing needs include an increase in the number and quality of human resources; integrating new methods and technologies; strengthening civil registration and other administrative data sources, as well as migration statistics; disseminating data and democratizing data use; and making sure that population data inform policy decisions. A shift should be made from dependence on survey data to a balanced use of all relevant data sources, including civil registration and other administrative data sources.

3. More systematic, inclusive participation.

754. While States continue to bear the primary obligation to ensure human rights, it is increasingly recognized that achieving good governance and development is the responsibility of a variety of non-State actors. Thus, the promotion of favourable conditions for free and inclusive participation of all stakeholders — Governments, parliamentarians, civil society and others, representing a diversity of opinions, interests and skills, as recognized in the Programme of Action — remains a priority. Improvements and innovations have been introduced, but greater efforts must be made to redress inconsistencies and foster the inclusive, transparent participation of

all key population groups in the decisions that affect them, including adolescents and youth, persons with disabilities, older persons and indigenous peoples.

4. Better accountability systems are needed for national and global programmes, as well as for the emerging complexity of development partnerships.

755. As a cornerstone of good governance, systems of accountability build a foundation for realizing rights-based development objectives; ensure that quality data and knowledge are accessible to the public and all decision makers; and create enabling environments that allow the informed representative participation of civil society to hold Governments and other key actors to account. National and international legislation, administrative practices and protection systems are needed to ensure equal access to programmes and services, prevent abuses, address systemic gaps and failures, and provide opportunities for redress and remedy. Mechanisms of review and oversight, including national human rights protection systems, courts, administrative review bodies, parliaments and forums for community participation are critical to this process. Equally important, effective international, multilateral, regional, South-South and triangular cooperation must be grounded in principles of national ownership, system-wide coherence, transparency and accountability to ensure that development aid and new global partnerships harness development potential, rather than increase fragmentation and duplicate efforts.

VI. Sustainability

> "The right to development must be fulfilled so as to equitably meet the population, development and environment needs of present and future generations."
>
> (Programme of Action, principle 3)
>
> "The objective is to raise the quality of life for all people through appropriate population and development policies and programmes aimed at achieving poverty eradication, sustained economic growth in the context of sustainable development and sustainable patterns of consumption and production, human resource development and the guarantee of all human rights, including the right to development as a universal and inalienable right and integral part of fundamental human rights."
>
> (Programme of Action, para. 3.16)
>
> "Modify unsustainable consumption and production patterns through economic, legislative and administrative measures, as appropriate, aimed at fostering sustainable resource use and preventing environmental degradation."
>
> (Programme of Action, para. 3.29 (d))

756. Scheduled only two years after the United Nations Conference on Environment and Development (the Earth Summit), the International Conference on Population and Development was profoundly imprinted by the goal of "sustainable development". Attention to sustainable development has only increased in the intervening 20 years, especially now as the world constructs a new agenda for global development. The operational review defined the unfinished agenda of the International Conference on Population and Development within the context of a new development environment that is shaped by, and must respond to, a need to

reconcile rising levels of consumption, threats to the environment, and growing wealth and income inequality. The fact that the poor bear the brunt of environmental burdens, and that the accustomed model for improving living standards, expanding opportunities and guaranteeing dignity and human rights is inherently unequal and proving unsustainable, is one of the major ethical quandaries in human history. At this challenging threshold, the core message of the International Conference on Population and Development — that a fundamental commitment to individual dignity and human rights is the basis of a resilient and sustainable future — can define a set of pathways to addressing this quandary and achieving sustainable development for all.

A. The heterogeneity of population dynamics

757. Rapid population growth in the twentieth century gave rise to widespread and heavily politicized concerns about overpopulation and the possibility that the world would not be able to generate enough food or other essential resources to sustain its people.[518] The urgent need for the pro-rights platform of the International Conference on Population and Development reflected decades of population and development policies that prioritized population control without heed to people's reproductive aspirations, their health, or the health of their children. The Programme of Action reflected a remarkable consensus among diverse countries that increasing access to health and education, and greater human rights for women, including their reproductive health and rights, would ultimately secure a better social and economic future, and also lead to lower population growth, than efforts targeted at birth control. The evidence of 2014 overwhelmingly supports the accuracy of that consensus.

758. There were an estimated 5.7 billion people in the world at the time of the International Conference on Population and Development in 1994. Global population has now reached 7.1 billion, and continues to grow by some 82 million people per year. However, in the intervening period, global annual population growth rates have been steadily declining, from 1.52 per cent in the period 1990-1995 to an estimated 1.15 per cent in the period 2010-2015. Annual rates of population growth have declined in developing countries as well, from an average of 1.8 per cent in the period 1990-1995 to 1.3 per cent in the period 2010-2015.

759. Africa's population is growing the fastest, at an estimated 2.3 per cent per year during the period 2010-2015, a rate more than double that of Asia (1.0 per cent per year). Nevertheless, in 2011, 60 per cent of the global population lived in Asia and only 15 per cent in Africa. Asia's population is currently 4.2 billion, while the population of Africa surpassed 1 billion only in 2009. The populations of all other major regions combined (the Americas, Europe and Oceania) amounted to 1.7 billion in 2011.[519]

760. Global and regional population trends mask considerable and growing heterogeneity of demographic experiences around the world. The demographic transition associated with declining fertility and mortality levels, together with the urban transition that has shifted the locus of human activity from rural to urban areas, have caused unprecedented changes in population size, age structures and spatial distribution.

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[518] P. R. Ehrlich, *The Population Bomb* (New York, Ballantine Books, 1968).

[519] *World Population Prospects: The 2012 Revision* (see footnote 336 above).

761. A comparison of the periods 1990-1995 and 2010-2015 shows that, while global total fertility rates declined by 16 per cent,[520] notable differences in fertility rates are observed across and within countries and regions.[519] Developed countries and some middle-income countries are now experiencing below-replacement fertility levels (that is, when women are not having enough children to ensure that, on average, each woman is replaced by a daughter who survives to the age of procreation), declining population growth rates and, in some cases, declining population size. Low-fertility countries include all countries in Europe, 23 of the 51 countries in Asia, 18 of the 38 countries in the Americas, 2 countries in Africa and 1 in Oceania.[519]

762. In the period 2010-2015, total fertility rates are expected to remain high, at four children per woman or greater, in 45 developing countries, including 18 countries where total fertility was five children per woman or greater. High-fertility countries are mostly concentrated in Africa (38 of the 57 countries in the continent have high fertility rates), but there are five in Asia and two in Oceania.[519]

763. As fertility declines, child dependency ratios decline, resulting in a population with relatively more working-age adults (15-59 years) and fewer non-working-age dependants. In developed countries, the proportion of the population of working age increased steadily, from 61.8 per cent in 1990 to 62.9 per cent in 2005. Since then, the proportion has been declining, and in 2010 it was at the same level as in 1990. In developing countries, the proportion of the population of working age increased considerably, from 56.8 per cent in 1990 to 62.4 per cent in 2010, and is projected to decline to 58.4 per cent in 2050. Among the least developed countries, the proportion of the population of working age is expected to rise from 53.8 per cent in 2010 to 59.8 per cent in 2050, and decline thereafter.[519]

764. The diversity in fertility levels illustrates a broader diversity of demographic trajectories between countries. Low-fertility countries are increasingly being faced with the opportunities and challenges of ageing as their citizens live longer and healthier lives. Countries that are witnessing rising proportions of youth and working-age populations owing to recent declines in fertility can take advantage of a short-term demographic dividend under the right social and economic conditions. And countries that have high fertility continue to experience rapid population growth, creating challenges in building capabilities in education and health and generating sufficient employment opportunities. While mortality has been declining and people are living longer in almost all countries of the world, a number of developing countries continue to have unacceptably high rates of morbidity and mortality and low life expectancy.

765. International migration, while not necessarily increasing in scale, has diversified in an interconnected and interdependent world, with many countries sending, receiving and being points of transit for migrants at the same time. And countries all around the world are at widely different stages of urbanization, with stable urban populations in Europe and North America coinciding with rapid urban growth and consequent declines of rural populations in Asia and Africa.

766. The operational review has shown that population dynamics matter for development and shape critical aspects of dignity, health, place and mobility. The rise in heterogeneity means that population dynamics are contextually specific and dependent on many other aspects of the different development paths that countries are taking. Too often, however, population dynamics, and particularly population

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[520] Period estimates provided here differ from the point estimates in the introduction, accounting for the difference in the stated fertility decline.

size and growth, are treated as undifferentiated and global in discussions about other phenomena that are indeed global. Climate change, one of the most important challenges for sustainability, is fundamentally global; its trajectory is dependent on the intersection of population and models of economic growth, production and consumption, and it will demand global responses. Understanding this intersection is therefore essential for creating pathways to sustainable development.

B. The drivers and threats of climate change

767. The current development paradigm is predicated on a social and economic model that favours production, accumulation and the consumption of goods and services in ever-greater amounts.[521] Increasing consumption is vital to improving well-being for the poor, yet at high income levels the benefits of further consumption result in no discernable impact on well-being.[522] While global population growth is slowing, levels of production and consumption have increased, and are expected to accelerate as long as natural resources can sustain them. Global GDP increased by a factor of 73 between 1820 and 2008, while world population increased only seven times.[523] Average consumption per capita almost tripled between 1960 and 2006.[524] Such economic gains have helped to bring relief from stark poverty to hundreds of millions of people, with particularly notable gains made in the last two decades. The number of people living on less than $1.25 per day fell from over 2 billion in 1990 to under 1.4 billion in 2008 while global population was increasing by almost 1.5 billion, underscoring both significant progress and the enormous number of people left behind.[525]

768. Economic progress has taken place at the expense of the environment. The risks of ignoring our planet's global environmental limits in pursuit of ever-rising production and consumption levels are growing exponentially. It is estimated that anthropogenic activities have already or will soon surpass ecological thresholds with respect to critical Earth systems and natural cycles. Most urgent are biodiversity, the

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[521] T. Veblen, *The Theory of the Leisure Class: An Economic Study of Institutions* (New York, Macmillan, 1899; 1915 edition available online); N. Georgescu-Roegen, "The entropy law and the economic problem", in *Valuing the Earth: Economics, Ecology and Ethics*, H. E. Daly and K. N. Townsend, eds. (Cambridge, MIT Press, 1993), pp. 75-88; N. Georgescu-Roegen, "Energy analysis and economic valuation", *Southern Economic Journal*, vol. 45, No. 4 (1979), pp. 1023-1058; H. E. Daly, *Steady-State Economics*, 2nd ed. (Washington, D.C., Island Press, 1991); N. Stern, *Stern Review on the Economics of Climate Change* (United Kingdom, H. M. Treasury, 2006); T. Jackson, *Prosperity Without Growth? The Transition to a Sustainable Economy* (Sustainable Development Commission, 2009); Worldwatch Institute, *State of the World 2010: Transforming Cultures — From Consumerism to Sustainability* (New York, Norton and Company, 2010); E. Assadourian, "The rise and fall of consumer cultures", in *State of the World 2010: Transforming Cultures — From Consumerism to Sustainability*, Worldwatch Institute (New York, Norton and Company, 2010).

[522] E. Diener and M. E. P. Seligman, "Beyond money: toward an economy of well-being", *Psychological Science in the Public Interest*, 5(1): vol. 5, No. 1 (2004), pp. 1-31.

[523] A. Maddison, University of Groningen, "Statistics on world population, GDP and per capita GDP, 1-2008 AD", 2010; available from www.ggdc.net/maddison/oriindex.htm; and *World Population Prospects: The 2012 Revision* (see footnote 336 above).

[524] Worldwatch Institute, *State of the World 2010: Transforming Cultures — From Consumerism to Sustainability*.

[525] *The Millennium Development Goals Report 2012* (United Nations publication, Sales No. E.12.I.4).

nitrogen cycle and climate change, with other serious concerns including degradation of land and soils, excess production of phosphorus, stratospheric ozone depletion, ocean acidification, global consumption of fresh water, changes in land use for agriculture, and air and chemical pollution.[526]

769. The consensus of scientific discussions today is that human activity is at the root of these various pressures. In the case of climate change, our carbon footprint is the critical factor. The concentration of CO_2 and other greenhouse gases in the atmosphere continues to increase — the level of 400 parts per million has been surpassed for the first time in three million years[527] — with the challenge of keeping global mean temperature rise below the critical threshold of 2 degrees Celsius above the preindustrial level only increasing in difficulty.[528] Rising levels of atmospheric CO_2 and other greenhouse gases are causing increased global temperatures, climate change and ocean acidification.[529] Rises in temperatures will accelerate the melting of glaciers and permafrost, which could lead to the liberation of trapped methane gas (CH_4), which is 30 times more potent than CO_2, though with a much shorter half-life. The copious and expanding use of fossil fuels as energy sources, including in buildings and transport, represents the main source of greenhouse gas emissions.[530] The longer it takes to reduce greenhouse gas emissions, whether by shifting to renewable energy or through other means, the more severe the economic disruption will be of both climate change and efforts to mitigate it.[531]

770. Climate change, as well as broader environmental degradation, poses a threat to the livelihoods and well-being of all societies and individuals. Yet the impacts of climate change — both acute and long-term — are likely to be worse for the poor and marginalized, who have contributed little to greenhouse gas emissions and at the same time lack the resources and societal supports to adapt effectively to current

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[526] UNEP, *UNEP Yearbook 2012: Emerging Issues in our Global Environment* (Nairobi, 2012).

[527] United States, Department of Commerce, National Oceanic and Atmospheric Administration, Earth System Research Laboratory, Global Monitoring Division, Up-to-date weekly average CO_2 at Mauna Loa. Available from www.esrl.noaa.gov/gmd/ccgg/trends/weekly.html.

[528] Potsdam Institute for Climate Impact Research and Climate Analytics for the World Bank, *Turn Down the Heat: Why a 4° C Warmer World Must Be Avoided* (Washington, D.C., World Bank, November 2012).

[529] Intergovernmental Panel on Climate Change, "Summary for policymakers", in *Climate Change 2013: The Physical Science Basis. Contribution of Working Group I to the Fifth Assessment Report of the Intergovernmental Panel on Climate Change*, T. F. Stocker and others, eds. (Cambridge, Cambridge University Press, 2013).

[530] Estimates vary but fossil fuels still account for over 80 per cent of the world's energy needs. As noted by Murphy, fossil fuels represent a generous one-time gift from the Earth; no other energy source can provide all the same benefits but fossil fuel stocks are finite; see T. W. Murphy, Jr., "Beyond fossil fuels: assessing energy alternatives", in *State of the World 2013: Is Sustainability Still Possible?*, Worldwatch Institute (Washington, D.C., 2013); T. Princen, J. P. Manno and P. Martin, "Keep them in the ground: ending the fossil fuel era", in *State of the World 2013: Is Sustainability Still Possible?*; and V. Smil, *Energy Transitions: History, Requirements, Prospects* (Santa Barbara, California, Praeger, 2010).

[531] National Research Council, *Hidden Costs of Energy: Unpriced Consequences of Energy Production and Use* (Washington, D.C., National Academies Press, 2010); E. Zencey, "Energy as master resource", in *State of the World 2013: Is Sustainability Still Possible?*, Worldwatch Institute (Washington, D.C., Island Press, 2013); S. Makhijani and A. Ochs, "Renewable energy's natural resource impacts", in *State of the World 2013: Is Sustainability Still Possible?*; C. A. S. Hall, S. Balogh and D. J. R. Murphy, "What is the minimum EROI that a sustainable society must have?", *Energies*, No. 2, No. 1 (2009), pp. 25-47; N. Stern, *The Economics of Climate Change: The Stern Review* (Cambridge, Cambridge University Press, 2006).

and future changes.[532] Climate change therefore presents humanity with extremely difficult decisions at the crossroads of development, equality and sustainability. The negotiations at the Conferences of the Parties to the United Nations Framework Convention on Climate Change have brought these issues to the forefront, and the lack of progress to date — the world's inability to curtail the growth of emissions, and the lack of funding to prepare for or alleviate climate impacts — underscore how far we are from the transformations so vitally needed to stop the warming of the climate.

771. Technology has historically been relied upon to relieve natural resource constraints and environmental impacts through at least partial delinking of consumption and production from resource use and pollution. Technological progress can, and should, contribute to efforts aimed at reconciling economic growth, consumption and environmental resources. While certain technologies are proven and are being widely deployed, efforts to develop new, as-yet-unproven technologies will be critical to achieving the ambitious reductions in environmental impacts that will be required in the coming decades. In this regard, the development of a variety of renewable energy sources and storage technologies to substitute for the use of fossil fuels is a priority.[533] There are also many challenging technical problems to be resolved, for instance the intermittency and variability of wind and solar energy, the reliable integration of renewable energy generation into existing electric grids, the decreasing availability of rare earth elements used in wind turbines and electric cars, as well as the scarcity of other more common resources.[534]

772. Improvements in energy efficiency are critical to lessen the eventual scale of renewable energy deployment. Yet increased efficiency can reduce the price of energy, encouraging still greater use (a phenomenon known as the Jevons paradox). Energy conservation, even should the world transition to renewable energy, is therefore necessary for a sustainable future.

773. **States should remove all barriers to sustainability through increased use of clean technology and innovation, and promote and develop sustainable production and consumption patterns through research and technical cooperation between countries and regions, including mutually agreed sharing of all relevant technologies.**

774. The error that is habitually made in discussing demographics and climate change is to identify a larger population with greater emissions, that is, to equate one person with one unit of consumption. At present, however, only 2.5 billion people, a little more than a third of the world's population, could be considered as having consumption profiles that contribute to emissions.[535] Fewer than 1 billion of these people actually have a significant impact on emissions, and a smaller minority

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[532] C. B. Field and others, eds., *Managing the Risks of Extreme Events and Disasters to Advance Climate Change Adaptation: Special Report of the Intergovernmental Panel on Climate Change* (Cambridge, Cambridge University Press, 2012).

[533] R. Costanza, J. Farley and I. Kubiszewski, "Adapting institutions for life in a full world" in *State of the World 2010: Transforming Cultures — From Consumerism to Sustainability*, Worldwatch Institute (New York, Norton and Company, 2010).

[534] Worldwatch Institute, *State of the World 2013: Is Sustainability Still Possible?*

[535] "Consumers" are defined in an analysis conducted by Mckinsey and Company as those with an income of at least 10 dollars a day. Such a low bar obviously inflates the number of people who are making significant contributions to emissions; it is nevertheless useful in establishing the fact that a minority of the world's population are actually consumer/emitters.

is responsible for an overwhelming share of the damage. All people should be sharing the Earth's resources, but if they did so in the manner and at the rate of the developed countries, our ecological support system would have broken down long ago.

775. While the immediate stabilization of population size would clearly improve the situation in the long term, it would make little difference to our current global ecological predicament. With very few exceptions, countries displaying higher levels of consumption have fertility levels that are already low or below replacement level. Hence, their population growth is due to net in-migration or inertia (that is, a result of the fertility levels of previous generations and thus to the number of women currently of reproductive age), and is not amenable to significant changes via family planning programmes. Indeed, many of these countries are actually trying to increase the fertility of their populations.

776. On the other hand, the countries with higher fertility rates tend to be mired in poverty and have very low levels of consumption. Poor countries and their populations have the right to development and to improve their living standards, a feat that in today's world requires higher economic growth. According to this scenario, their consumption profiles will, and should, increase, and unless this increase happens in a radically different manner than has been the case for wealthier countries, it will further contribute to climate change.

777. Another important aspect of population and development that is generally ignored is the link between fertility changes and consumption. As a society develops, individuals and households are motivated to reduce their fertility for various complementary reasons, including a decline in infant mortality and increased consumption aspirations. Declines in fertility, in turn, are associated with higher per capita income in the household unit and, thus, with greater capacity to consume. Consequently, if family planning programmes are effective in reducing fertility, success in reducing emissions will be highly dependent on the extent and nature of consumption and economic growth.

C The cost of inequality in achieving sustainable development

778. The global development model has brought many out of poverty. However, prevailing inequalities in income, living standards and, more generally, opportunity remain at the root of economic, social, environmental and political segmentation, with 8 per cent of the world population accumulating 82 per cent of global wealth as part of a trend of steeply rising wealth inequality for the past 20 years.

779. When growing inequality precludes human well-being for vast numbers of people, every part of society is impacted. Inequality is a threat to social cohesion, empathy and shared responsibility because it generates and exacerbates social segmentation. This is true politically, where economic resources significantly determine political access, influence and outcomes, and socially, because it diminishes the likelihood that people with varying degrees of wealth and income will share neighbourhoods, meet within schools, and gain the chance for shared

understanding and empathy. It also constrains class mobility and therefore people's ability to emerge out of poverty and achieve more secure livelihoods.[536]

780. A broadly educated, healthy, secure and empowered population is the goal of development, and also necessary for inclusive economic growth. States that actively promote the capabilities of their people, provide universal public services, govern effectively and efficiently, fight discrimination and are shaped by the political participation of their people are able to generate more equal development.[537] As inequality grows, the ability and will of Governments to provide a strong common foundation of capabilities for all of their people is degraded. And when people experience discrimination, because of income, gender, ethnicity or race, disability status, sexual orientation or gender identity or other factors, their health, dignity and ability to maximize their capabilities and contributions are deeply impacted, at great cost to all of society.[538]

781. The degradation of the environment only compounds the extent and impacts of inequality. The poorest bear most of the environmental costs of industrial waste and by-products, and are extremely impacted by climate change. Rising inequality also further threatens the ability of the world to provide for all. The creation of wealth requires natural resources; diversion of the vast majority of the world's wealth, and therefore its finite resources, to a small part of the population limits the resource base for poverty reduction and the extension of rights-based development to present and future generations. These challenges underscore the need for equitable living conditions for all persons over their life course, and fair distribution of the risks and health consequences of industry.

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[536] J. S. Hellman and D. Kaufmann, "The inequality of influence", Social Science Research Network working paper, available from http://papers.ssrn.com/sol3/papers.cfm?abstract_id=386901; M. Corak, "Income inequality, equality of opportunity, and intergenerational mobility", *Journal of Economic Perspectives*, vol. 27, No. 3 (2013), pp. 79-102; K. Bjorvatn and A. W. Cappelen, "Inequality, segregation, and redistribution", *Journal of Public Economics*, vol. 87, Nos. 7-8 (2003), pp. 1657-1679.

[537] J. Dreze and A. Sen, *An Uncertain Glory: India and its Contradictions* (Princeton, New Jersey, Princeton University Press, 2013).

[538] Krieger, "Embodying inequality: a review of concepts, measures, and methods for studying health consequences of discrimination"; Pascoe and Smart Richman, "Perceived discrimination and health: a meta-analytic review"; Williams, Neighbors and Jackson, "Racial/ethnic discrimination and health: findings from community studies"; Williams and Mohammed, "Discrimination and racial disparities in health: evidence and needed research" (see footnote 176 above).

Human rights elaborations since the International Conference on Population and Development

Box 31

Right to development

Intergovernmental human rights outcomes. The Human Rights Council, reaffirming the Declaration on the Right to Development (1986) and emphasizing the urgent need to make the right to development a reality for everyone, adopted a series of resolutions, including resolution 21/32 on the right to development (2012), in which the Council took note of the activities of the Working Group on the Right to Development and the process of developing criteria and corresponding sub-criteria for monitoring the implementation of the right to development.

Other soft law. In resolution 17/4 (2011), the Human Rights Council endorsed the Guiding Principles for Business and Human Rights: Implementing the United Nations "Protect, Respect and Remedy" Framework, which provide a global standard for preventing and addressing adverse impacts of business activities on the enjoyment of human rights.

Government priorities: interaction between population and sustainable development

Social sustainability, poverty reduction and rights	70 per cent of Governments
Environmental sustainability	52 per cent of Governments
Integration of population dynamics in sustainable development	43 per cent of Governments
Physical infrastructure development	40 per cent of Governments
Health and education	35 per cent of Governments

782. Government responses to the global survey suggest widespread acknowledgement that social and environmental sustainability must be at the core of inclusive development, and that economic growth is the means for, rather than the measure of, social well-being. When asked to identify the population and sustainable development issues anticipated to receive priority in public policy for the next 5-10 years, the most frequently listed issue was "social sustainability, poverty reduction and rights", the priority of 70 per cent of Governments. This was followed by "environmental sustainability" (52 per cent); only 25 per cent listed "economic growth" as a priority.

D. Paths to sustainability: population and development beyond 2014

783. Notable progress has been celebrated in the preceding sections of this report, highlighting the central success of the paradigm, adopted by Member States at the International Conference on Population and Development 20 years ago, that protection of individual human rights and the advancement of gender equality would not only accelerate inclusive development, but contribute to a further deceleration of population growth. Accomplishments since 1994 have been substantial, opening the door for further opportunity to reflect on unfulfilled goals for sustainable development beyond 2014, and within the post-2015 agenda.

784. Recommendations in each of the preceding sections have elaborated technical, institutional and political changes needed to fulfil human rights; achieve better health, public knowledge and participation; ensure more secure and accessible options for settlement; and generate more robust systems of accountability. While each recommendation in this framework can be addressed on its own, they echo and complement one another and provide a foundation for achieving sustainable development, as summarized in the following seven paths to sustainability.

1. Strengthen equality, dignity and rights

785. For the past 20 years, the principles set forth by Member States at the International Conference on Population and Development, that all persons are "free and equal, in dignity and rights", have guided efforts to expand human rights protection systems and means of accountability, in particular to fulfil and protect the reproductive rights of women and young people. At the same moment that much progress can be celebrated, discrimination and lack of opportunity remain a daily reality for many women, girls, young persons, older persons, migrants, persons with disabilities, indigenous peoples, ethnic and racial minorities, persons of diverse sexual orientation and gender identity, people living with HIV, refugees, sex workers and others.

786. Human rights violations against women and girls, including gender-based violence; harmful practices, such as child, early and forced marriage and female genital mutilation/cutting; women's and girls' unequal access to education; and women's unequal access to employment, leadership and decision-making constitute major threats to their dignity and well-being and that of their families and communities, as well as barriers to the achievement of inclusive sustainable development. The full realization of gender equality and women's empowerment is therefore imperative.

787. Further, the evidence reviewed herein highlights a growing body of social research demonstrating that stigma, discrimination and violence, and thereby the exclusion of persons from full participation in society, have costs that are manifest not only in the physical and mental health of those affected, but in their restricted productivity and achievements. In order to secure the tremendous benefits to development of human creativity, innovation, diligence and productivity, far greater investment, now and in the future, is required to create more just, non-discriminatory, non-violent societies.

788. The population and development agenda set out in 1994 remains strong, yet unfulfilled, and the agenda beyond 2014 should be based on the recognized universality of human rights and dignity for all persons, in present and future generations. It is necessary to ensure that the sectoral benefits outlined in the

Programme of Action reach all persons in order to end the intergenerational transmission of poverty and build sustainable, adaptive and cohesive societies.

2. Invest in lifelong health and education, especially for young people

789. The principled need for good health and quality education, including comprehensive sexuality education, must be reaffirmed and inform multiple sectors of government and private-sector investments. Lack of education and ill-health are the most common risk factors and manifestations of poverty, curtailing economic growth and human well-being and limiting the capability of both individuals and societies to innovate and thrive in a changing world. Investments in the education and health of girls and women have been historically neglected but, as evidenced by the contribution to global development in the past 20 years resulting from women's greater empowerment and education and the progressive realization of their reproductive rights, they provide especially high returns for societies.

790. The largest demographic cohort of young people in human history is about to enter the workforce, and their success will define development trajectories not only for sub-Saharan Africa and Central Asia, where they represent a high proportion of the population, but for the entire world, given our increasingly interconnected and globalized economies. The opportunity is upon us for enriching the lives of preparing young people and providing them with the capabilities they will need to expand their individual choices and shape the innovative and sustainable future of the planet.

791. As societies age — a phenomenon occurring in many countries now and in many more in the coming decades — the legacies of undereducation persist, underscoring the need for a lifelong approach to education. Such an approach will enable older persons to contribute to changing economies, thereby providing a second demographic dividend via an engaged, experienced and well-trained older workforce.

792. While the present report underscores the progress made by many countries in sexual and reproductive health and in improving access to and achieving gender parity in school enrolments, the achievements have not reached many who need them most, and who were most deprived in 1994. The capabilities of the world's poorest citizens, both urban and rural, remain untapped owing to poor-quality schools, fragile and understaffed health systems, the diversion of public profits through corruption and the prioritization of short-term economic returns. The differences in progress towards development over the past 20 years in States that have reinvested in public capabilities versus States that have failed to prioritize such investments highlight the essential nature of these investments for long-term economic growth, public health and population well-being.[537]

3. Achieve universal access to sexual and reproductive health and rights

793. For most of the world's women, and young women in particular, the struggle for individual human rights and the freedom to decide on their personal future has been a historic struggle, one that is far from won. The extent to which societies have tolerated the use of force and violence to sustain patriarchal control over women, in diverse countries and across all classes of society, is one of the great injustices of human history. If women are to contribute to the enrichment and growth of society, to innovation and to development, they must have the opportunity to decide on the number and timing of their children, and to do so free from violence or coercion, with full confidence that pregnancy and childbirth can be entered into without grave

fear of illness, disability or death, and with confidence in the likelihood that their children will survive and be healthy.

794. Early marriage is not a guarantee of social protection, and leads to many of the health risks of early childbearing and often an end to a young women's education. Postponing early marriage and childbearing provides the time for young women to develop their capabilities, move outside the household or migrate to a new place, enter the labour market and earn income, and embark on marriage and motherhood with greater autonomy and knowledge. Delayed marriage and childbirth also saves lives: complications from pregnancy and childbirth together are the main cause of death among adolescent girls 15-19 years old in developing countries.[539]

795. Gender equality cannot be achieved unless all girls and women can make free and informed choices about sex and reproduction; this demands renewed investment to ensure universal access to quality sexual and reproductive health and rights for all. The review highlighted persistent inequalities in access to health services and resulting poor sexual and reproductive health outcomes for many, especially mortality and morbidity among poor women during pregnancy and childbirth, including from unsafe abortion.

796. The achievement of universal access to quality sexual and reproductive health and rights for all demands urgent renewed investments directed towards holistically strengthening health systems, thereby bringing these critical services to where people live. This should be a core dimension of proposals for universal health coverage. Further, structural inequalities and other barriers to access, including those due to stigma and discrimination, must be addressed to fully ensure the necessary realization of sexual and reproductive health and rights for all.

4. Ensure security of place and mobility

797. Migration is an intrinsic feature of a globalizing world, in which people increasingly have information and access to different places, both within and beyond their national borders. In some places, poverty, lack of opportunities, or the lack of investment in capabilities lead people, in particular young people, to migrate internally or abroad to secure better wages, generate remittances and expand their opportunities for a better life. For young women living under highly patriarchal conditions, such migration is increasingly recognized as a search for freedom and autonomy that may seem impossible in their place of origin.

798. For some, then, migration is less a choice than a necessity for family or individual survival. Migration exists along a continuum from forced to voluntary, with very few migration decisions entirely one or the other.[540] Sustainability through security of mobility and place means ending forced migration and supporting people who do want to move. For those who want to remain where they are, it means building better livelihood options and creating social conditions of dignity, equality and opportunity, in order to decrease what the Programme of Action referred to as push factors. Even absent push factors, however, many want to migrate to improve their social or economic condition. For those who do, freedom to move means removing the obstacles faced by migrants or potential migrants,

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[539] UNFPA, *Sexual and Reproductive Health for All: Reducing Poverty, Advancing Development and Protecting Human Rights* (New York, 2010).

[540] G. Hugo, "Environmental concerns and international migration", *International Migration Review*, vol. 30, No. 1 (1996), pp. 105-131.

embracing their contributions to societies of destination as well as origin, and protecting migrants and members of their families from discrimination or other forms of exclusion. Investments in communities of origin and destination have to be supported by the promotion and protection of human rights and fundamental freedoms of all persons, irrespective of their migratory status, and by combating all forms of discrimination that migrants face, including the violence and exploitation faced by women and girls.

799. While some internal and international migrants may achieve their goals, other people are not able to leave their places of origin, lacking the freedom or resources to move, living in conditions of heightened insecurity, extreme poverty and vulnerability. Some have lost their homes and land and are homeless, while others have been displaced within their country or have moved to another country as a result of conflict. All persons, whether internal migrants, international migrants, homeless persons, internally displaced persons or refugees, should be provided with access to education, health care and social protection, their safety and security ensured and their social integration fostered.

5. Build sustainable, inclusive cities

800. As the world's cities and towns are currently growing at a rate of more than 1.3 million people a week, planning for urbanization and building sustainable cities should be a priority focus for countries undergoing urban transition. Cities that are accepting population growth, are connected to the rural areas around them and deliver services for the poor are a key part of sustainable development and of the effective development of rural areas.

801. Future environmental outcomes depend to a great extent on the decisions that are made with respect to location and patterns of urban settlement and growth. Cities present significant potential advantages in terms of conciliating the economic and demographic realities of the twenty-first century with the demands of sustainability and of coping with the effects of climate change. It is widely recognized that, controlling for income, urban concentration is more resource efficient and, with its advantages of scale, allows for more sustainable land use. Moreover, the protection of biodiversity and of natural ecosystems, including the conservation of natural forests, depends on the absorption of population in densely populated areas. Environmentally oriented proactive urban planning, including improved energy efficiency, especially in the transport and housing sectors, could transform cities into a vital part of the solution to climate change and other environmental challenges.[541] The fact that the world is undergoing a dramatic urbanization process, particularly in Africa and Asia, where much of the world's population growth will be, is therefore an enormous opportunity for sustainability, if the right policies are put in place.

802. These policies must combine the aims of resource efficiency and minimized environmental impact with ensuring that cities are designed for and deliver dignity, human rights and opportunity for the poor and marginalized, both in the city and beyond. Strong links between cities and rural areas that facilitate access to the city and the flow of people and resources can stimulate markets, improve access to services and create opportunity. As people move to cities, vital to their security of place is ensuring sufficient affordable housing, given that urban growth and density

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[541] *World Economic and Social Survey 2013: Sustainable Development Challenges* (United Nations publication, Sales No. E.13.II.C.1).

tend to drive up prices and increase the risk of excluding the poor. "Development-based evictions"[542] are one of the most common causes of displacement of the urban poor. They are often framed as being for the public good, but in practice they violate the human rights of the poor and undermine their dignity and opportunities. At the 2005 World Summit, world leaders committed to slum prevention and upgrading in order to eliminate widespread practices of slum clearance and evictions. Justice systems need the authority to enforce these commitments and to protect the security of land tenure, particularly for women, who are often denied inheritance, and for both women and indigenous groups, who are often denied property ownership in practice, if not in law.

803. Widespread participation in urban governance can help ensure that urban policies address the needs of the most vulnerable. Such participation needs to be institutionalized, for instance via dedicated budgets and the formal inclusion of civil society organizations and marginalized communities, which can help to prevent capture of governance systems by the elite and deliver governance by all and for all.

6. Change patterns of consumption

804. A fundamental change to patterns of consumption is required to slow down the frenetic waste of natural resources, to refocus development aspirations on achieving dignity for all and to enrich prospects for human dignity for future generations. Without marked changes in consumption behaviour and material aspirations, particularly among those at the top end of the consumption curve, who account for so great a drain on resources, new technology and improvements in business and transport practices can only delay impending disasters.

805. Change in consumption begins at the societal level. The base contributions to consumption — our modes of transport, our housing options, our utilities — are significantly determined by the organization and the public infrastructure of the societies in which we live. In this light, one of the most established, effective and just means of change that Governments can undertake to introduce efficiencies and ensure that physical, social and economic opportunities are equally accessible and beneficial to all is the generation and maintenance of universal, cost-efficient public infrastructures and services. Vital public services include clean water; communication systems; a strong, functioning public health system; regulated utilities; and energy-efficient public transport systems. These goods, which are primarily the responsibility of Government to deliver, provide critical means of reducing individual, hence overall, consumption, while at the same time realizing dignity and creating opportunity.

806. Investing in public services has an immediate and tangible impact on all individuals and societies as a whole. Additionally, the yields from such investments are in many cases transferred to future generations, whose capabilities are in turn expanded. The benefits of changing our consumption patterns on the environment are unlikely to be witnessed by our generation. However, this abstract perception

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[542] Evictions often planned or conducted under the pretext of serving the "public good", such as those linked to development and infrastructure projects, including large dams, large-scale industrial or energy projects, or mining and other extractive industries; land-acquisition measures associated with urban renewal, slum upgrades, housing renovation, city beautification, or other land-use programmes, including for agricultural purposes; property, real estate and land disputes; unbridled land speculation; major international business or sporting events; and, ostensibly, environmental purposes. For more information, see the basic principles and guidelines on development-based evictions and displacement (A/HRC/4/18, annex I).

must not distance us from our shared responsibility to improve opportunity for future generations.

807. Individuals also bear responsibility for sustainable consumption. While those at the bottom end of the income distribution curve have little or no choices regarding consumption, and indeed consume comparatively little, people with higher incomes have significant choices, and too often choose high consumption. As more and more people recognize the risks of climate change and other human impacts on the environment, incentives for reducing consumption, together with innovations to generate viable means of consuming less without declines in well-being, will help make different choices a reality.

808. While the International Conference on Population and Development offered a paradigm shift in 1994 regarding how the world weighed individual human rights against fears of overpopulation, a cultural paradigm shift is again required, one that recognizes that well-being is not, and must not, be based solely on increasing consumption. In order to sustain the rights-based individual and development principles in the Programme of Action, a collective shift should be made towards individual well-being derived from modes of living and livelihoods that are more equitable and have less impact on the environment, with a radical change of focus on innovation and more effective collective action on global challenges.

7. Strengthen global leadership and accountability

809. Global leadership and knowledge-based accountability are required to achieve progress in the six areas described above, through political will, wide civil society participation, and the generation and use of knowledge to monitor sustainable development commitments.

810. The nature and gravity of these intersecting problems make global leadership a critically important concern at a time when global governance is unfortunately poor, particularly when it involves addressing the intersecting needs for accountability regarding human rights, poverty reduction, highly variable economic and demographic trends in different countries, and the urgent and long-term need to protect the environment.

811. Expectations for global consensus were raised in advance of the fifteenth session of the Conference of the Parties to the United Nations Framework Convention on Climate Change, held in Copenhagen in 2009. The meeting was the most prominent of the broad-based sustainable development negotiations to take place since the early 1990s, and its failure to make significant progress created widespread disillusionment with international conferences. There were lower expectations of subsequent Conferences of the Parties, and of the United Nations Conference on Sustainable Development, held in Rio de Janeiro, Brazil, in 2012, and these expectations have not been exceeded.[543] Considering the history of past attempts to create the institutions of global governance,[544] these difficulties are not surprising, even when there is widespread agreement that the stated goals are laudable.

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[543] I. Goldin, *Divided Nations: Why Global Governance is Failing, and What We Can Do About It* (Oxford, Oxford University Press, 2013).

[544] M. Mazower, *Governing the World: The History of An Idea* (New York, Penguin Press, 2012).

812. New systems of leadership and participation may be needed, ensuring democratic participation of all population groups in governance processes and public institutions for the ensured delivery of investments that promote social, economic and environmental sustainability. But participation and leadership also demand sound and accessible information on population dynamics, human rights, present and emerging trends in social and economic equality and the pending threats to the environment, as a basis for shared priority-setting, policymaking, budgeting and accountability. The revolution in information technology provides the potential to bring this information to people around the world, including young people and those who are marginalized and deprived, thereby creating a foundation for broader knowledge, transparency and inclusion.

E. Beyond 2014

813. The past 20 years have seen widespread support expressed across diverse societies for the central agreements secured at the International Conference on Population and Development in 1994, namely, that investing in individual human rights, capabilities and dignity, across multiple sectors and through the life course, is the foundation of sustainable development. The framework of actions based on the operational review calls for a holistic approach to sustainable development that recognizes the interlinkages between human rights, non-discrimination, women's equality, sexual and reproductive health, population dynamics, development and sustainability, and between planning, implementation and accountability for results.

814. In the light of current social and economic inequalities, threats to the planet and the findings of the review, present and future development choices must be shaped by a greater sense of common humanity and unyielding respect for the principles and objectives set forth in the Programme of Action of the International Conference on Population and Development. Young people are growing up with an increasing awareness that human actions are threatening the environment. This reality, combined with growing access of young people to collective knowledge and communication, gives rise to the hope that innovations will enable a sustainable future.

815. Effective collective action on the global challenges outlined in this framework, on the basis of the findings of the review, would require the leadership of the General Assembly and the Secretary-General, in cooperation with the governing bodies of the organizations of the United Nations system, to undertake a review of the existing institutional and governance mechanisms for addressing global issues with a view to ensuring effective coordination, integration and coherence at national, regional and global levels consistent with the scale of the comprehensive response required to ensure rights-based sustainable development.

816. The special session of the General Assembly on the follow-up to the Programme of Action of the International Conference on Population and Development beyond 2014 provides the defining opportunity to act on the findings and recommendations of the operational review for the further implementation of the Programme of Action beyond 2014, and the Assembly is invited to consider ways to integrate them into its initial consideration of the post-2015 development agenda, as well as into the preparations for the special session, in order to fully extend the principles of equality, dignity and rights to future generations and ensure sustainable development.

Annex

Monitoring framework for the Programme of Action of the International Conference on Population and Development beyond 2014

Monitoring framework matrix

Programme of Action beyond 2014	*Illustrative indicators*		
Objectives and areas of measurement	*Input structure*	*Effort process*	*Outcome/impact*
I. Ensure dignity, human rights and non-discrimination for all			
1. Eradicate poverty and promote equitable livelihood opportunities	Date of entry into force and coverage of domestic laws for implementing the right to social security, including in the event of sickness, old age, unemployment, employment-related injury, maternity and/or paternity, disability or invalidity, and for survivors and orphans Full employment as a policy objective of central banks (reflected in their statutes) and Governments (reflected in their election programmes) Measures to support those at the bottom, including through minimum wage legislation; freedom to form unions and engage in collective bargaining Date of entry and coverage of domestic laws for implementing the right to work, including regulations to ensure equal opportunities for all and eliminate employment-related	Percentage of poor receiving cash or other periodic income support Proportion of unemployed covered by unemployment benefits, by sex Proportion of older persons (60+/65+) with access to old-age pensions, by sex Indicators reflecting social protection floors* An indicator on lifelong learning*	Proportion of population below internationally accepted poverty line (current poverty line = US$ 1.25 PPP per day) Proportion of population below national poverty line Share of poorest quintile in national consumption Consumption/income growth of the bottom 40 per cent (percentage in real per capita consumption/income) Working poor (proportion of employed people living below US$ 1.25 PPP per day) Proportion of children under age 5 who are underweight Employment-to-population ratio in the working age population, by sex, target group and educational level An indicator of unpaid domestic or family care work*

Programme of Action beyond 2014	*Illustrative indicators*		
Objectives and areas of measurement	*Input/structure*	*Effort/process*	*Outcome/impact*
	discrimination, as well as special measures for target groups (women, children, migrants, indigenous persons)		Unemployment rate, by sex, age and location Proportion of labour force participating in social security scheme(s)*
2. **Empower women and girls, reduce all forms of violence against women, and achieve gender equality**	Duration of maternity, paternity and parental leave Existing property and inheritance laws do not discriminate against women and girls Existing laws against child marriage, including legislation stating a minimum age of marriage of 18 years	Use of a gender quota in elections (reserved seats for women in a legislative assembly; legislated reserved places on electoral lists for female candidates; and voluntary political party quota) An indicator on national mechanisms to monitor and reduce gender-based violence* An indicator on efforts towards enforcing equality in inheritance and property rights An indicator on efforts towards enforcing laws against child marriage* Gender pay gap Proportion of population with access to institutional credit (other than microfinance), by sex	Share of women in parliament Share of women among persons in managerial positions Proportion of women and men in wage employment Proportion of adult population owning land, by sex Proportion of women aged 20-24 who were married or in union before age 18 Proportion of women aged 15-49 subjected to physical or sexual violence in the last 12 months Proportion of women aged 15-49 who have undergone female genital mutilation/cutting

Programme of Action beyond 2014	*Illustrative indicators*		
Objectives and areas of measurement	*Input structure*	*Effort process*	*Outcome impact*
3. **Invest in the capabilities of children, adolescents and youth**	Time frame and coverage of national policy on education for all, including provision for temporary special measures for target groups (working and street children) Minimum age for employment by occupation type stipulated by law National policy on vocational education and skill upgrading	Proportion of primary school and secondary teachers fully qualified and trained Pupil/teacher ratio Budget spent by Governments on programmes for school-to-work transition An indicator on the quality of education*	Primary completion rate, by sex Adjusted net enrolment ratio in secondary education by sex Proportion of adolescents who achieve recognized and measurable learning outcomes Number of young people not in education, employment or training, by sex Proportion of children in productive activity, by sex Duration of waiting time between end of school and first job, by sex and target groups
4. **Eliminate discrimination and promote a culture of respect for all**	Existence of laws prohibiting discrimination against all persons Time frame and coverage of policy for the elimination of forced labour, including worst forms of child labour, domestic work and work of migrants, and human trafficking Time frame and coverage of national policy for persons with disabilities	An indicator on the quality of curricula promoting a culture of respect for all* HIV-related stigma among health facility staff* An indicator on efforts towards enforcing anti-discrimination laws*	An indicator on fear of violence* Prevalence/incidence of crimes, including hate crimes, by target groups* Proportion of relevant positions in the public and private sectors held by target population groups

Programme of Action beyond 2014	*Illustrative indicators*		
Objectives and areas of measurement	*Input structure*	*Effort process*	*Outcome impact*
II. Strengthen health systems to ensure universal access to sexual and reproductive health			
1. **Strengthen health-care systems to accelerate progress towards universal access to quality sexual and reproductive health services and fulfilment of sexual and reproductive rights**	Time frame and coverage of national policy integrating sexual and reproductive health Health systems governance policy index (WHO)	Share of health expenditure in total government expenditure Percentage of population living within two hours' travel time from health facilities that offer sexual and reproductive rights services Proportion of births attended by skilled health personnel Proportion of primary health-care facilities offering sexual and reproductive health services/ family planning services Health information system performance index (WHO) Indicators on human resources for health*	Mother-to-child HIV transmission rate An indicator on the quality of sexual and reproductive health services* An indicator of access to health facilities and essential medicines*
2. **Protect and fulfil the rights of adolescents and youth to accurate information, comprehensive sexuality education and health services for their sexual and reproductive well-being and lifelong health**	Remove legal barriers towards sexual and reproductive health services for adolescents and youth, including inconsistencies in legal protection that can create age-related barriers	An indicator gauging the quality of sexual and reproductive health information and services targeting adolescents and youth* Proportion of adolescents who have received comprehensive sexuality education and information on sexual and reproductive health, gender equality and human rights, among adolescents in or out of school	Adolescent birth rate Proportion of women aged 20-24 who had a pregnancy before age 18 Proportion of never married women and men aged 15-24 using a condom at last sex Percentage of young women and men aged 15-24 who correctly identify ways of preventing sexual transmission of HIV and who reject major misconceptions about HIV Youth HIV prevalence rate

Programme of Action beyond 2014	*Illustrative indicators*		
Objectives and areas of measurement	*Input structure*	*Effort process*	*Outcome/impact*
3. **Strengthen specific sexual and reproductive health services, including family planning; post-abortion care; maternity care; and sexually transmitted infections, including HIV**	Grounds on which abortion is permitted	Dedicated budget line for family planning Dedicated budget line for contraceptive commodity procurement Extent to which sexual and reproductive rights/family planning is integrated into post-partum, post-abortion and HIV services (e.g., through referral, within same facility, fully integrated within same visit) An indicator on informed choice* New and/or increased resources are committed to sexual and reproductive health services in the last two years Government share of total spending on sexual and reproductive health services* Percentage of facilities reliably offering a range of methods, encompassing four categories of contraceptive methods: short term; long-acting reversible; permanent; and emergency contraception Percentage of facilities that report not being out of stock of a modern form of contraception in the past six months	Unmet need for family planning Contraceptive prevalence rate Antenatal care coverage (one and four visits), by wealth quintile Proportion of births attended by skilled health personnel, by wealth quintile Number of deaths due to unsafe abortion Maternal mortality ratio Neonatal mortality Antiretroviral therapy coverage An indicator on sexually transmitted infections prevalence* Maternal morbidity indicators including: Rate of obstetric fistula, rate of uterine prolapse and rate of severe anaemia. Percentage of adults aged 15-49 who received an HIV test in the past 12 months and know their results

Programme of Action beyond 2014	*Illustrative indicators*		
Objectives and areas of measurement	*Input structure*	*Effort process*	*Outcome/impact*
		Percentage of primary health-care facilities providing sexual and reproductive health/family planning services Percentage of primary health-care facilities with rapid diagnostic tests for sexually transmitted infections available Regional Supply Hub availability and readiness (WHO Service Availability and Readiness Assessment (SARA)) Emergency obstetric care service density per 20,000 births	
4. **Address the rising burden of non-communicable diseases through the promotion of healthy behaviours beginning in childhood and adolescence, and by providing routine screening, early treatment and referrals to higher levels of care**	National health policy includes health promotion and non-communicable diseases, taking into account a life-course approach	An indicator reflecting Governments' efforts in promoting healthy behaviour at all ages* An indicator reflecting Governments' efforts in promoting healthy behaviours among children and adolescents through school programmes* Public investments in routine screening* General availability of routine screening at the primary health-care level (WHO indicator) Proportion of health facilities able to screen for non-communicable diseases	Cervical and breast cancer incidence, prevalence, and mortality Prevalence of adult obesity, by sex Prevalence of diabetes, by sex Youth and adolescent heavy episodic drinking, by sex* Probability of dying between exact ages 30 and 70 from cardiovascular disease, cancer, diabetes or chronic respiratory illness, by sex Mortality rate due to priority non-communicable diseases, by sex

Programme of Action beyond 2014 –	*Illustrative indicators*		
Objectives and areas of measurement	*Input structure*	*Effort/process*	*Outcome/impact*
		Current smoking of any tobacco product (age-standardized rate and youth rate), by sex	Prevalence of deaths, injuries and diseases and disabilities caused by unsafe natural and occupational environment
III. **Ensure security of place and safe mobility**			
1. **Ensure that the needs of persons living in an emerging diversity of households are included in public policies, including urban planning**	Data on one-person households and single-parent households are produced and used in public policies, including urban planning	Public expenditure on social protection, by programme and target population group	Proportion of one-person households and single-parent households receiving social protection benefits, by sex of household head
2. **Extend the full benefits of urban life to all current and future urban residents, taking into account projections of urban population growth**	Existence of national non-restrictive internal migration policy Data on urbanization trends are produced and used in public policies, including urban planning Time frame and coverage of national housing policy or strategy for the progressive implementation of measures, including special measures for target groups, for the right to adequate housing Urban Governance Index (UN-Habitat)	Percentage of municipal budget allocated to excluded/vulnerable groups Percentage of municipal budget allocated to public spaces Percentage of municipal budget allocated to mass transportation Appropriately zoned public space per resident Share of urban energy from low-carbon sources An indicator reflecting disparities between and within urban areas* Average income-to-rent ratio Urban green space per resident	Proportion of urban population living in slums Proportion of population with access to an improved water source Percentage of population with access to an improved sanitation facility Proportion of population with access to electricity Proportion of population with access to weekly solid waste collection Percentage of urban residents using public transportation

Programme of Action beyond 2014	Illustrative indicators		
Objectives and areas of measurement	*Input/structure*	*Effort/process*	*Outcome/impact*
3. **Promote the developmental benefits of international migration**	Existence of laws that ensure equal access to health services for international migrants Number of bilateral and regional agreements on the recognition of qualifications of international migrants Number of bilateral and regional agreements signed and implemented on portability of social security	Number of State-led programmes facilitating temporary, virtual or permanent return of skilled and qualified diaspora members Average cost of transfer of remittances at both origin and destination ends Indicators on costs of migrant recruitment* An indicator on the cost of international migration*	Proportion of international migrants accessing health services Proportion of international migrants having access to formal financial banking and remittance services An indicator on the well-being of international migrants* An indicator on human trafficking*
4. **Improve the living conditions and guarantee the full social inclusion of those lacking security of place**	Existence of legislation guaranteeing equal inheritance Existence of legislation protecting against forced evictions Existence of temporary protection policies, including shelter	Emergency preparedness plans incorporate sexual reproductive health services	Proportion of internally displaced persons Proportion of refugees Proportion of homeless* Reported cases of "forced evictions" in the reporting period*
IV. **Strengthen global leadership and accountability**			
1. **Strengthen national capacity to generate, disseminate and effectively use population and reproductive health data and projections in the formulation of sustainable development strategies/policies**	Estimated proportion of births, deaths and marriages recorded through vital registration systems	Dedicated budget line for strengthening national statistical capacity Indicator reflecting effort in donor financing policies and planning procedures to avoid duplication, identify funding gaps and ensure that resources are used as effectively and efficiently as possible*	Data availability to monitor the beyond 2014 monitoring framework* Indicators to improve tracking of resources committed to all four population categories: family planning services; basic reproductive health services; sexually transmitted diseases/HIV/AIDS activities; and basic

Programme of Action beyond 2014	*Illustrative indicators*		
Objectives and areas of measurement	*Input/structure*	*Effort/process*	*Outcome/impact*
		Indicator reflecting increased role of the private sector in the mobilization of resources for population and development*	research, data and population and development policy analysis*
2. **Ensure that budgeting and policymaking processes are transparent and establish quality assurance mechanisms to redress shortfalls in both public and private sector services**	Date of entry into force and coverage of administrative tribunals or dedicated judicial redress mechanisms	Number of registered NGOs or active NGOs (per 100,000 persons) involved in the monitoring and implementation of States' commitments in specific areas	Indicator on transparency and corruption* Indicators on social participation by target groups* Indicator on international collaboration and partnerships*

* Including areas of measurement needing to be developed/improved or indicators where data are available for a very limited number of countries (see para. 8 below).

Monitoring implementation of the Programme of Action beyond 2014

1. The monitoring framework is guided by the human rights conceptual framework and therefore focuses on measuring the commitments of duty bearers to their obligations and the efforts they undertake to meet these obligations. The framework also includes indicators of impact/results or the extent to which holders' rights are met.

2. The framework reaffirms the core message of the Programme of Action, namely that the pathway to sustainable development is through the equitable achievement of dignity and human rights, good health, security of place and mobility, and achievements secured through good governance; and that governance responsibilities extend to the national and global promotion of integrated social, economic and environmental sustainability in order to extend opportunity and well-being to future generations.

3. For each of the main thematic domains of the Programme of Action beyond 2014 operational review, objectives and sub-objectives are specified based on the key areas of further actions identified in the operational review. The sub-objectives were discussed by theme and were later reviewed together to ensure that there was no overlap. Illustrative areas of measurement along the continuum commitments-effort-result were identified for every sub-objective.

4. A few principles have been used in developing this proposed monitoring framework; the framework should include a small number of indicators. This will reduce the burden of data collection in low-income countries. It will also make it easier to hold countries accountable for progress. National capacity for data collection and analysis should be assessed and capacity-building considered in the context of monitoring efforts. In that connection, one of the major recommendations of the present report is for countries to take significant steps to establish or improve systems for registration of births, deaths and causes of death.

5. The framework should focus on indicators of efforts, as they are more sensitive to progress. For example, while improved health outcomes are ultimately what is needed under the health objectives, health status indicators are relatively insensitive to change and need time to show progress. Effort and process, on the other hand, are often easier to track and the framework includes process/effort indicators that can act as tracers of changes in health status. These indicators are expected to be highly associated with the outcome indicators.

6. Equality and non-discrimination are key aspects of the Programme of Action beyond 2014, and they should be adequately addressed in the monitoring framework. Data collection should enable the disaggregation of data by gender, age, minority status and wealth quintile. Disability and other health conditions limiting access to health care or other services should be noted. Spatial inequalities should be addressed by ensuring data are collected in remote and underserved areas. Data collection should include information so as to enable analysis that looks at regional and subnational differentials and trends.

7. One of the main limitations of the illustrative indicators of the Millennium Development Goals framework is that they were defined by the existing data collection mechanisms. It is expected that further work will be initiated to strengthen the beyond 2014 monitoring framework by exploring and developing new monitoring tools and developing and testing new indicators to capture

information on the emerging issues, and new priorities identified in the framework of actions for the follow-up of the Programme of Action of the International Conference on Population and Development beyond 2014.

8. The work required should include a technical process on measurability to review the proposed indicators in terms of formulation (numerator/denominator, clarity, periodicity, comparability, cost-effectiveness) and recommended steps to validate the measurability of those indicators that are currently not yet systematically collected at the international level. The expected results should include:

(a) An agreed-upon final list of selected indicators to be included in the monitoring framework, along with information on their operational definition and relevant information on their coverage, update cycle and parent organization/agency;

(b) Recommendations for future work and a clear research agenda to develop/improve indicators and/or data collection mechanisms along three dimensions, taking into account the differences with regard to clarity of definition, tested validity, availability of data, and feasibility and ease of data collection, namely:

(i) Normative work: provide standard definitions and create measurement and reporting tools; this will include identifying and gauging alternative data sources for new indicators;

(ii) Testing and validation: pilot and validate indicators in the field, and improve measurement and reporting tools;

(iii) Advocacy and communication: promote the use of some indicators within existing measurement and reporting tools.

9. The process should involve seeking inputs from diverse partners/stakeholders and ensure linkage to global and regional events (the Accountability Commission, the WHO Partnership for Maternal, Newborn and Child Health (PMNCH) and Family Planning 2020 (FP2020) partnership, etc.) and make clear proposals to leverage synergies, taking advantage of complementary efforts at the country and global levels.

10. The follow-up process would also require translating the monitoring framework into an action workplan that outlines the objectives, main approach, specific country, and global actions, roles and responsibilities of partners and ways to monitor progress of the implementation of the workplan. The global reporting, oversight and accountability mechanism under the workplan will require feedback from the main partners and stakeholders.